IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

ARTHUR F. QUERN, Director, Illinois Department of Public Aid, et al.,

Appellants,

vs.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation; and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

On Appeal from the United States District Court for the Northern District of Illinois, Eastern Division

JURISDICTIONAL STATEMENT

WILLIAM J. SCOTT,
Attorney General of the State of Illinois,
160 North LaSalle Street,
Chicago, Illinois 60601,
Attorney for Appellant Quern.

WILLIAM A. WENZEL, III
Special Assistant Attorney General,
130 North Franklin Street, Suite 300,
Chicago, Illinois 60606,
(312) 793-2380,
Of Counsel.

July, 1979

Printed by Authority of the State of Illinois 365

INDEX

TABLE OF AUTHORITIES

CASES: PAGE

FEDERAL STATUTES AND REGULATIONS

STATE STATUTES

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. ——

ARTHUR F. QUERN, Director, Illinois Department of Public Aid, et al.,[1]

Appellants,

vs.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation; and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

On Appeal from the United States District Court for the Northern District of Illinois, Eastern Division

---

JURISDICTIONAL STATEMENT

---

1. Jasper F. Williams, M.D., and Eugene F. Diamond, M.D., and the United States, intervening defendants below, are also appellants in this case.

Appellant, Arthur F. Quern, Director of the Illinois Department of Public Aid, defendant below, appeals from the Final Judgment and Order of the United States District Court for the Northern District of Illinois, Eastern Division, entered April 30, 1979. Appellant submits this Jurisdictional Statement to show that this Court has jurisdiction of this Appeal and that the questions presented are so substantial as to require plenary consideration, with briefs on the merits and oral argument, for their resolution.

OPINIONS BELOW

The Memorandum Opinion of the District Court, dated April 29, 1979, is unreported and appears in the Appendix hereto at p. A-21, *infra*. Prior opinions of the United States Court of Appeals for the Seventh Circuit are reported at 572 F. 2d 582 (7th Cir. 1978) ("Zbaraz I") and 596 F. 2d 196 (7th Cir. 1979) ("Zbaraz II"). "Zbaraz II" is reprinted in the Appendix hereto at p. A-1, *infra*.

JURISDICTION

This is a class action brought under the Civil Rights Act (42 U.S.C. § 1983) challenging an Illinois statute, P.A. 80-1091, insofar as it is alleged to deny indigent, pregnant women public funds for abortions deemed "medically necessary" by their physicians. Plaintiffs claim that Illinois' failure to fund all "medically necessary" abortions under its public assistance programs violates their rights under Title XIX of the Social Security Act (Medicaid) (42 U.S.C. § 1396 *et seq.*) and the Ninth and Fourteenth Amendments to the United States Constitution. The action in its present posture also involves the constitutional validity under the Fifth Amendment to the United States Constitution of a federal statute, Section 210, Pub. L. 95-480 (1978) (an

amendment to Title XIX, commonly known as the "Hyde Amendment"), which permits states participating in the Medicaid program to limit funding to the categories of abortions specified in that amendment.

The Final Judgment and Order of the District Court for the Northern District of Illinois, invalidating on equal protection grounds both the Illinois and federal statutes, was entered on April 30, 1979. See, p. A-43, *infra*.

Appellant Quern filed his original notice of appeal to this Court in the District Court on May 2, 1979. An amended notice of appeal was duly filed on May 8, 1979. See, p. A-56, *infra*.

This appeal is being docketed in this Court within sixty (60) days from the filing of the original notice of appeal in accordance with Supreme Court Rule 13(1). The jurisdiction of this Court in being invoked under 28 U.S.C. § 1252. The following cases sustain the jurisdiction of this Court to review the judgment below on direct appeal from the District Court: *International Ladies' Garment Workers' Union* v. *Donnelly Garment Co.*, 304 U.S. 243 (1938); United *States* v. *Raines*, 362 U.S. 17 (1960); and *McLucas* v. *DeChamplain*, 421 U.S. 21 (1975).

CONSTITUTIONAL PROVISIONS INVOLVED

Fifth Amendment, United States Constitution:

> No person shall . . . be deprived of life, liberty, or property, without due process of law . . .

Ninth Amendment, United States Constitution:

> The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

Fourteenth Amendment, United States Constitution:

> Section 1. . . . No State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

STATUTES INVOLVED

Section 210, Pub. L. 95-480, 92 Stat. 1586:

> None of the Funds provided for in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.
>
> Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the termination of an ectopic pregnancy.

P.A. 80-1091, Ill. Rev. Stat. Supp. (1977) ch. 23 §§ 5-5, 6-1, 7-1:

> § 5-5. *Medical Services.*
>
> The Illinois Department, by rule, shall determine the quantity and quality of the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: . . . (15) any other medical care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature birth, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.

> § 6-1. *Eligibility requirements.*
>
> • • •
>
> Nothing in this Article shall be construed to permit the granting of financial aid where the purpose of such aid is to obtain an abortion, induced miscarriage or induced premature birth unless, in the opinion of the physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.
>
> § 7-1. *Eligibility requirements.*
>
> Aid in meeting the costs of necessary medical, dental, hospital, boarding or nursing care, or burial shall be given under this Article to or in behalf of any person who meets the eligibility conditions of Section 7-1.1 through 7-1.3, except where such aid is for the purpose of obtaining an abortion, induced miscarriage or induce premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.

QUESTIONS PRESENTED

1. Whether state funding of abortions necessary for the preservation of the life or the physical or mental health of an indigent woman as determined in accordance with the professional judgment of a licensed physician exercised in light of all factors relevant to her health, is a fundamental constitutional right.

2. Whether the Fourteenth Amendment's equal protection clause imposes a constitutional obligation upon the State of Illinois to fund all medically necessary abortions prior to fetal viability to preserve the physical or mental health of pregnant indigent women without regard to classifications based on kind and degree of medical need.

3. Whether the State of Illinois, through its normal democratic processes may make a value judgment favoring child birth over abortion and to implement that judgment by the allocation of public funds based upon kind and degree of medical need to preserve the physical health of pregnant indigent women.

4. Whether P.A. 80-1091 as modified by the Hyde Amendment to the Social Security Act imposes an unreasonable standard of predictive certainty upon medicaid physicians for certification of abortions where "the life of the mother would be endangered . . . or . . . where severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term . . ." which results in a substantial increase in maternal morbidity and mortality among indigent pregnant women.

STATEMENT OF THE CASE

Appellant, Arthur F. Quern, is Director of the Illinois Department of Public Aid and in that capacity is responsible for the administration of the Illiois Public Aid Code, *Ill. Rev. Stat.*, Ch. 23, § 1-1 *et seq.* (1977). The Illinois Department of Public Aid is the "single state agency" designated to administer the Illinois state plan for medical assistance pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396a(a)(5); *Ill. Rev. Stat.*, Ch. 23, § 5-1 *et seq.* (1977).[2] Director Quern is a defendant in this action.

In 1977 the Illinois Legislature in response to the decisions of this Court in *Beal* v. *Doe*, 432 U.S. 438 (1977); *Maher* v. *Roe*, 432 U.S. 464 (1977) and *Poelker* v. *Doe*, 432 U.S. 519 (1977), and Congressional enactment of the "Hyde Amendment" to Title XIX of the Social Security Act [Pub. L. 94-439, § 209, 90 Stat. 1434] enacted P.A. 80-1091, *Ill. Rev. Stat. Supp.* (1978) Ch. 23, §§ 5-5, 6-1, 7-1 which excluded from the scope of its medical assistance program medical services and payment for abortions unless in the opinion of the physician an abortion is "necessary for the preservation of the life of the woman seeking such treatment".

Shortly after its enactment, P.A. 80-1091 was challenged by the plaintiffs in this case by the filing of a class action under the Civil Rights Act (42 U.S.C. § 1983) in the Dis-

---

2. Director Quern also administers two wholly state authorized and funded public assistance programs—the Genally Assistance program, *Ill. Rev. Stat.* (1977) ch. 23, § 6-1; the Aid to the Medically Indigent program, *Ill. Rev. Stat.* (1977) ch. 23, § 7-1 *et seq.*

trict Court. Alleging jurisdiction under 28 U.S.C. § 1331 and 28 U.S.C. § 1343(3), (4), plaintiff-physicians Zbaraz and Motew claimed that P.A. 80-1091 denied them and their indigent women patients needing medically necessary abortions their rights under the Social Security Act, and the Ninth and Fourteenth Amendments to the United States Constitution. Complaint, ¶ 1. Plaintiffs sought declaratory and injunctive relief for themselves and on behalf of two classes of persons affected by the statute, namely, a physician class and a class of all aggrieved women patients of such physicians.

On December 13, 1977, Jasper F. Williams, M.D. and Eugene F. Diamond, M.D., pursuant to Rule 24(a)(2), Federal Rules of Civil Procedure, sought leave of court to intervene in the lawsuit as parties defendant in order to protect their own economic interests and for the purpose of representing the interests of unborn children which would be impaired by a ruling in favor of the plaintiffs. The motion for intervention was opposed by the plaintiffs and was accordingly taken under advisement by the court.

Because the District Court believed that the "life-preservation" standard utilized in P.A. 80-1091 could be interpreted by Illinois courts in a way that would avoid the federal statutory and constitutional challenges, an abstention order was entered by the District Court on December 21, 1977 in order to give the Illinois courts an opportunity to definitively construe the new legislation in the face of a claim that the statute excluded funding for "medically necessary" abortions as defined by the plaintiffs.

Plaintiffs appealed the abstention order to the United States Court of Appeals for the Seventh Circuit. Pending the outcome of the appeal, the Seventh Circuit issued an

injunction against enforcement of the Illinois statute and compelled the state to fund all "therapeutic" abortions. Relying on this Court's language in *Doe* v. *Bolton,* 410 U.S. 179, 192 (1973), the Court of Appeals defined "therapeutic" to mean "medically necessary or medically indicated according to the professional medical judgment of a licensed physician in Illinois, exercised in light of all factors affecting a woman's health." In *Zbaraz* v. *Quern,* 572 F. 2d 582 (7th Cir. 1978) ("Zbaraz I") the Seventh Circuit reversed the District Court's abstention order but intimated no view on the merits of the relief plaintiffs were seeking. The Court dissolved its injunction and remanded the case for expeditious consideration of preliminary injunctive relief.

On remand, plaintiffs filed a motion for leave to have Jane Doe joined as a party plaintiff and for leave to file amended and supplemental pleadings. The motion alleged that Jane Doe was a recipient of Aid to Families with Dependent Children ("AFDC") public assistance, 42 U.S.C. §§ 601 *et seq.,* and medical assistance under the "Medicaid" program, 42 U.S.C. § 1396 *et seq.* Plaintiff Doe was described as a 38 year old woman who had had nine previous pregnancies, was pregnant again and desired to have an abortion. Accompanying the motion was the affidavit of David Zbaraz, M.D. which stated that he had reviewed the medical records of Jane Doe who had recently been examined by two other physicians on the staff of Michael Reese hospital in Chicago, Illinois. Those records disclosed that Jane Doe had a history of varicose veins and thrombophlebitis (blood clots) of the left leg. In Dr. Zbaraz's professional opinion, on the basis of the medical records he reviewed, Jane Doe's varicose veins would recur if her pregnancy were to continue and there existed a 30% risk

that the thrombophlebitis would recur necessitating hospitalization and bed rest if the fetus were carried to term.

Dr. Zbaraz concluded that an abortion was medically necessary for Jane Doe, though not necessary to preserve her life. The District Court by Order of April 25, 1979 granted plaintiffs leave to join Jane Doe as a party plaintiff and permitted the filing of amended pleadings. Thereafter the parties, including the movants for intervention as party defendants, filed cross motions for summary judgment.

On May 15, 1978 the District Court issued a memorandum opinion which (1) granted the motion to intervene of Jasper F. Williams, M.D. and Eugene F. Diamond, M.D.; (2) certified two Rule 23(b) (2) classes;[3] (3) denied Defendant Quern's motion to dismiss for want of jurisdiction; and (4) granted plaintiff's motion for summary judgment based solely on the statutory issues raised in the complaint.

The court found that Section 209 of Pub. L. 95-205 (the "Hyde Amendment" to the Departments of Labor and Health, Education and Welfare Appropriations Act for 1978) was not intended by Congress to alter the substantive requirements of Title XIX with respect to state funding of medically necessary abortions. Construing Title XIX to oblige participating states to fund all medically neces-

3. The classes certified by the District Court consist of (1) all pregnant women eligible for the Illinois medical assistance programs for whom an abortion is medically necessary but not necessary for the preservation of their lives and who wish such abortion performed, and (2) all Illinois physicians who are certified to obtain reimbursement for necessary medical services rendered to and who perform medically necessary abortions for, persons eligible for medical services under [the "Illinois medical assistance programs"].

sary services, the District court concluded that P.A. 80-1091, by denying funds for abortions deemed "medically necessary" in the discretion of attending physicians, was inconsistent with the objectives of the Act, 42 U.S.C. § 1396, the "reasonable standards" requirement of § 1396a(a)(17) and implementing regulations governing the "amount, duration and scope" of services, 42 C.F.R. § 449.10(a)(5)(i).

Upon appeal to the United States Court of Appeals for the Seventh Circuit, that Court again reversed, *Zbaraz* v. *Quern,* 596 F. 2d 196 (7th Cir. 1979) ("Zbaraz II"), p. A-1, *infra.* The Court in "Zbaraz II", agreeing with First Circuit's decision in *Preterm, Inc.* v. *Dukakis,* 591 F. 2d 121 (1st Cir. 1979) *cert. denied,* —— U.S. ——, 47 L.W. 3739 (May 15, 1979), held that the Hyde Amendment to the Medicaid Act was intended by Congress to amend Title XIX in regard to abortions, and that under the Medicaid Act, as amended, Illinois could limit medicaid funding to the categories of abortions specified in that amendment. Consequently, Illinois was free to deny funding for all "medically necessary" abortions which a physician could not certify as falling under one of the designated Hyde Amendment categories.

There remained, however, in the Court's opinion serious constitutional issues which the District Court on remand was directed to consider, including "whether the Hyde Amendment, by limiting funding for abortions to certain circumstances even if such abortions are medically necessary, violates the Fifth Amendment in view of the facts that no other category of medically necessary care is subject to such constraints and that abortion has been recognized as a fundamental right." 596 F. 2d at 202; p. A13, *infra.*

Pursuant to the mandate of the Seventh Circuit, the District Court by Order dated February 15, 1979 (p. A17,

infra), modified its permanent injunction entered on May 15, 1978 so as to require Illinois to fund all Hyde Amendment abortions in its enforcement of P.A. 80-1091 thereby expanding eligibility for abortion funding to cover rape and incest victims and those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

Since the constitutionality of a federal statute had been drawn into question, Judge Kirkland certified this fact to the Attorney General of the United States pursuant to 28 U.S.C. § 2403(a), Order of February 22, 1979, (p. A19, *infra*) and directed the Attorney General to notify the court whether the United States intended to seek permission to intervene for presentation of evidence and for argument on the question of the Hyde Amendment's constitutionality.

Leave to intervene was granted the United States by Order of March 8, 1979 (p. A20, *infra*). Thereafter each party submitted to the Court a motion for summary judgment supported by briefs addressing the constitutional issues. Due to health reasons, Judge Kirkland recused himself prior to ruling and the case was reassigned to Judge Grady.

In a memorandum opinion dated April 29, 1979 (p. A21, *infra*) Judge Grady held that the Hyde Amendment and P.A. 80-1091 (as modified by court order) were constitutionally infirm as violative of the plaintiffs' right to equal protection of the laws. Finding that this Court's decision in *Maher* v. *Roe,* 432 U.S. 464 (1977) precluded any claim of a fundamental right to a state-funded abortion, or that a state's refusal to fund abortions amounted to an unconstitutional penalty, the Court declined to apply strict

judicial scrutiny to either statute and instead sought to determine if there were any legitimate state interests which were rationally related to the legislative classification at issue.

The Court rejected the state's purported interest in "fiscal frugality" since the costs attendant to childbirth far exceed those of abortion.[4] Furthermore, with respect to the state's acknowledged interest in fetal life, the Court found as a factual predicate that the employment of Hyde Amendment criteria will necessarily result in increased maternal morbidity and mortality among indigent pregnant women and consequently the State could have "no legitimate interest in preserving the life of a non-viable fetus at the cost of increase maternal morbidity and mortality." Memorandum Opinion, p. A37, *infra.*

Accordingly, Judge Grady granted partial summary judgment to both plaintiffs and defendants, Final Judgment and Order entered April 30, 1979, ¶4, p. A45, *infra.* The federal and state abortion funding policies were held unconstitutional as applied prior to fetal viability. After fetal viability, the court ruled that defendants were free under equal protection standards to enforce such policies.

Defendant Quern and intervening defendants Williams and Diamond requested the District Court to stay its Final

---

4. In briefing the constitutional issues, Appellant Quern never advanced the argument that P.A. 80-1091 was supported by an interest in "fiscal frugality". Rather, based upon Mr. Justice Powell's statements in *Maher*, the interest put forward was the authority of the state to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds for abortions based upon relative degrees of need, i.e. an interest in "fiscal autonomy".

Judgment and Order of April 30, 1979. In addition, Defendant Quern sought an order requiring the federal government to reimburse the State of Illinois for all medically necessary abortions required to be performed under the court's order with respect to recipients of medical assistance under Title XIX of the Social Security Act, 42 U.S.C. § 1396, since that Title contemplates a scheme of cooperative federalism under which participating states are reimbursed for approximately 50% of the total amounts expended for medical assistance. 42 U.S.C. § 1396b(a)(6). The Assistant United States Attorney representing the United States Government stated in open court that the Department of Health, Education and Welfare did not intend to reimburse Illinois for any non-Hyde Amendment medically necessary abortions which would be performed and funded under the District Court's Order. The District Court denied both stay motions and failed to act upon Defendant Quern's Motion for federal reimbusement. Orders entered April 30, 1979, p. A41, A42, *infra.*

On May 2, 1979, Defendant Quern filed his Notice of Appeal from the Final Injunction and Order of April 30, 1979, indicating that the appeal would be made directly to the Supreme Court of the United States. On May 8, 1979, the state defendant filed an Amended Notice of Appeal in order to fully comply with the requirements imposed by Rule 10, Rules of the Supreme Court, which provides that "the notice of appeal shall specify . . . the statute or statutes under which the appeal to this Court is taken". The Amended Notice specified that the appeal is pursuant to 28 U.S.C. § 1252.

Director Quern and intervenors Williams and Diamond then applied to Mr. Justice Stevens, Circuit Justice for the Seventh Circuit, for a stay of the order of the District Court, No. A-958, No. A-967. The Solicitor General on behalf of the United States filed a memorandum recommending that the applications for a stay should be granted. On May 24, 1979, Mr. Justice Stevens, in a written opinion which intimated no view on the merits of the appeal, declined to grant a stay. —— U.S. ——, 47 L.W. 3772 (May 29, 1979) Thereafter, applicants in No. A-958 brought the application for a stay before Mr. Justice Rehnquist who, in turn, submitted it to the entire Court which denied the application without opinion. —— U.S. ——, 47 L.W. 3786 (June 5, 1979).

THE QUESTIONS ARE SUBSTANTIAL

> [Abortion] involves the most basic and volatile principles about which men can differ: life, death, liberty, privacy, our traditions, our ideals, our moral values.
> *Byrn* v. *New York City Health & Hospital Corp.*, 38 App. Div. 2d 316, 324, 329 NYS 2d 722, 729, *aff'd.* 31 N.Y. 2d 194, 286 N.E. 2d 887, 335 NYS 2d 390 (1972).
>
> The Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents.
> *Maher* v. *Roe,* 432 U.S. 464, 469 (1977).

The question of the constitutional validity of the federal "Hyde Amendment" policy limiting government funding of abortions and its state progeny, such as Illinois' P.A. 80-1091, has never been given plenary consideration before by the Court.[5]

It is now well-settled that during the first trimester of pregnancy, the state may not infringe upon a woman's right to choose between childbirth and abortion. *Roe* v. *Wade,* 410 U.S. 113 (1973). During this period the right of a woman to seek an abortion and the right of her doctor to provide that abortion is considered a private matter:

> This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or

5. See, *Califano* v. *McRae,* 433 U.S. 916 (1977) vacating in the wake of *Maher* v. *Roe* a decision that had declared the Hyde Amendment to be unconstitutional.

> as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. 410 U.S. at 153.

It is equally well-established that a state constitutionally may decline to pay for "the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents." *Maher* v. *Roe,* 432 U.S. 464, 469 (1977).

The question arises whether, in conjunction with the administration of non-comprehensive medical assistance programs for indigents, federal or state legislative authorities may permissibly classify publicly-funded abortion services by kind and degree of need so as to prohibit payment for abortions in those instances where the risk of damage to maternal health is minimized and legislatively defined interests in fetal life, childbirth and fiscal autonomy are enhanced.

The decision below appears to be premised on the supremacy of individual medical judgment and opinion when it clashes with, or fails to comprehend, the collective economic and social judgment of the community. It elevates as a criterion of Fourteenth Amendment jurisprudence the amorphous concept of "medical necessity"[6] and scuttles the reasoning in *Maher* that sensitive policy choices in a

6. In the affidavit of Oren Richard Depp, M.D. submitted in support of plaintiffs' motion for summary judgment, the concept is defined as follows: "Where a 1% or higher risk of morbidity or mortality exist, together with a firm wish by the patient to terminate her pregnancy, I would consider an abortion to be medically indicated (or 'medically necessary' or 'therapeutic')." Affidavit of Oren Richard Depp, M.D., ¶ 11, pp. 6-7.

democracy are the province of the legislatures and not the courts.

Based upon the *legal* opinion of plaintiff Zbaraz that P.A. 80-1091 imposes on him an unreasonable standard of "predictive certainty" foreign to the medical profession, the District Court reaches the speculative conclusion that the effect of the Hyde Amendment criteria "will be to increase substantially maternal morbidity and mortality", p. A-36, *infra*. No attempt was made by the District Court to buttress this reasoning by references to the legislative histories and debates surrounding P.A. 80-1091 and the Hyde Amendment. Appellant Quern submits that no such standard of "predictive certainty" can be gleaned from those legislative histories. A fiat disclaimer of plaintiff's legal opinion can be found in comments made by the Secretary of Health, Education and Welfare accompanying the regulations implementing the Hyde Amendment. 43 Fed. Reg. 31876 (July 21, 1978). Taken together these observations, along with plaintiffs' concept of "medical necessity", raise the difficult question of the constitutional rights of private physicians, in furtherance of their own economic interests, to curtail governmental control and discretion of medical assistance programs for the indigent. See, *Association of American Physicians & Surgeons* v. *Weinberger*, 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd.* 423 U.S. 975 (1975).

The legislation at issue rationally furthers important governmental interests which have been legitimated in prior decisions of this Court. The state's interest in fetal life and the encouragement of childbirth were sufficient to overcome constitutional challenges in *Maher* v. *Roe, supra* and its companion case, *Poelker* v. *Doe*, 432 U.S. 519 (1977). That the State has a legitimate interest in fiscal autonomy

finds support in both *Maher* and *Poelker* which in turn derive their strength from *Dandridge* v. *Williams*, 397 U.S. 471 (1970).

In the balance is the "firm desire" of Jane Doe to abort her pregnancy in the face of some measure of risk to her health should she carry the fetus to term and her belief that the constitution compels the state to pay for the exercise of her right to choose to have an abortion prior to fetal viability.

Is the right to choose to abort created in *Roe* a "non-interference right" as suggested in *Maher* or does the factor of some small degree of medical risk alter the equation so as to trigger an obligation of state funding? Once the state decides to fund some of the medical expenses of the indigent must it fund all "medically necessary" abortions as defined by plaintiffs? Does the concept of fetal viability as related to maternal health really strip elected representatives of the people of the power to make controversial policy decisions in the area of economic and social welfare legislation?

Illinois State Senator Lemke, the sponsor of P.A. 80-1091, felt the answer to these questions was "no". As he stated in the debates prior to passage of the statute:

> My people don't want abortions being performed with their money. If it costs them more to support these children after they're born, they will pay that money gladly as long as it's properly used.
> (Memorandum Opinion, p. A33, *infra*.)

Appellant Quern submits that on a proper balancing of the interests involved in the case, this Court will find that the legislation at issue here is constitutional since the classifications made rationally further several important state interests and only minimally affect pregnant indigent women and their treating physicians.

CONCLUSION

For these reasons, this Court should note probable jurisdiction of this appeal.

Respectfully submitted,

WILLIAM J. SCOTT,
Attorney General of the State of Illinois,
160 North LaSalle Street,
Chicago, Illinois 60601,

Attorney for Appellant Quern.

WILLIAM A. WENZEL, III
Special Assistant Attorney General,
130 North Franklin Street, Suite 300,
Chicago, Illinois 60606,
(312) 793-2380,

Of Counsel.

July, 1979

IN THE

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Nos. 78-1669, 78-1709, 78-1787,
78-1890, 78-1891, 78-2029
DAVID ZBARAZ, et al.,

Plaintiffs-Appellees,

v.

ARTHUR F. QUERN,

Defendant-Appellant.

Appeal from the United States District Court for the
Northern District of Illinois, Eastern Division.
No. 77 C 4522—Alfred Y. Kirkland, *Judge.*

ARGUED NOVEMBER 1, 1978—DECIDED FEBRUARY 13, 1979.

Before CUMMINGS, SPRECHER, and BAUER, *Circuit Judges.*

CUMMINGS, *Circuit Judge.* This class action was brought under the Civil Rights Act (42 U.S.C. § 1983) to enjoin enforcement of a 1977 Illinois statute withdrawing medical assistance funding in Illinois for all abortions except those "necessary for the preservation of the life of the [pregnant] woman."[1] Plaintiffs do not object to the refusal to fund

---

1. Ill. Rev. Stat. Supp. (1977) ch. 23 §§ 5 5, 6-1, 7-1.

purely elective abortions, and challenge the limitation on funding only as to medically necessary abortions. They assert that the Illinois statute denies them and the classes they represent[2] rights guaranteed by Title XIX of the Social Security Act (Medicaid) (42 U.S.C. § 1396 *et seq.*) and by the Fourteenth Amendment to the United States Constitution.

Plaintiffs are two doctors whose practice includes the performance for indigent women of medically necessary abortions, most of which are not necessary for the preservation of their lives; the Chicago Welfare Rights Organization, whose members include women dependent on Illinois medical assistance benefits; and Jane Doe, an indigent woman requiring a medically necessary abortion but one that is not necessary to save her life. The principal defendant is Arthur F. Quern, Director of the Illinois Department of Public Aid, the state agency charged with administering the medical assistance programs and with enforcement of the statute in question. Two other doctors were allowed to intervene as defendants in the court below.

In December 1977 the district court issued an order abstaining from consideration of the case. Plaintiffs appealed

---

2. The classes certified by the district court consist of (1) all pregnant women eligible for the Illinois medical assistance programs for whom an abortion is medically necessary but not necessary for the preservation of their lives and who wish such abortion performed, and (2) all Illinois physicians who are certified to obtain reimbursement for necessary medical services rendered to, and who perform medically necessary abortions for, persons eligible for the Illinois medical assistance programs. Because of the injunction granted below, the state resumed its prior medical assistance funding for medically necessary abortions.

and this Court granted them an injunction pending appeal against enforcement of the Illinois statute insofar as it prohibits state funding for therapeutic abortions.[3]

In March 1978 we reversed the district court's abstention order but did not resolve the merits of plaintiffs' motion for a preliminary injunction. *Zbaraz* v. *Quern,* 572 F. 2d 582. Thereafter, the district court held that Title XIX of the Social Security Act and the regulations thereunder require Illinois to provide medical assistance funding for all therapeutic abortions. Judge Kirkland concluded that the Hyde Amendment on which defendants rely does not call for a contrary result.[4] Because the district court resolved the case on statutory grounds, plaintiffs' constitutional challenges were not resolved. The district court permanently enjoined defendants from denying payments under the Illinois medical assistance programs to the plaintiff physicians "and any other recognized and legal medical providers, for the rendition of medical services to indigent pregnant women for therapeutic abortions * * *." This injunction is still in effect.

---

3. Our injunction order defined "therapeutic" as "medically necessary or medically indicated according to the professional medical judgment of a licensed physician in Illinois, exercised in light of all factors affecting a woman's health." The district court employed this definition in its final judgment now here on appeal.

4. The Hyde Amendment (quoted *infra*) was first enacted as a rider to the FY 1977 Health, Education and Welfare appropriations bill. (Section 209 of Pub. L. 95-205; 91 Stat. 1460 Dec. 9, 1977).

This opinion starts with a caveat. This panel is interpreting Congressional and Illinois General Assembly laws as they are written. Our line of duty is to construe those laws, neither to condone nor criticize them. Moreover, we do not start with a clean slate, for six years ago the Supreme Court under the Due Process clause of the Fourteenth Amendment invalidated penal laws that restrict legal abortions to those "procured or attempted by medical advice for the purpose of saving the life of the mother." *Roe* v. *Wade,* 410 U.S. 113, 164. Very recently the Supreme Court reaffirmed that the right to secure an abortion in the early stages of pregnancy is a fundamental right. It also stressed that the abortion decision is primarily a medical one and emphasized the central role of the physician in helping to reach that decision. *Colautti* v. *Franklin,* —— U.S. ——, 47 LW 4094. With those admonitions in mind, our task is readily charted.

The Court of Appeals for the First Circuit has recently ruled on a challenge to the Massachusetts abortion funding law that is nearly identical to the challenge mounted here to the similar Illinois law. *Preterm, Inc.* v. *Dukakis,* —— F. 2d —— (1st Circuit, Nos. 78-1324, 78-1325, and 78-1326, decided January 15, 1979). We agree with Judge Coffin's majority opinion in that case.[5]

---

5. Two other courts have also recently handed down opinions in similar cases. In *Roe* v. *Casey* (E.D. Pa., decided December 21, 1978, 47 L.W. 2461) the district court held that a state could not exclude medically necessary abortions as a category of care funded under Medicaid. It is not clear from the abbreviated report whether the court intended that the state pay for abortions which are medically necessary but not funded under the Hyde Amendment.

In *Frieman* v. *Walsh* (W.D. Mo. No. 77-4171-CV-C, decided January 26, 1979), the court similarly held that a

(Footnote continued on next page)

The First Circuit held in *Preterm* that Title XIX of the Social Security Act does not require funding of all medical care which is deemed "necessary" by the treating physician, but that it does prohibit a state from singling out medically necessary abortions as a category of care which would be funded only under certain narrow circumstances. The *Preterm* court concluded that for a state so to discriminate in the care it provided would conflict with the statutory provision that state-established standards for determining the extent of medical assistance should be "reasonable" and "consistent with the objectives" of the Medicaid Act. 42 U.S.C. § 1396a(a)(17). These objectives include furnishing medical assistance "to meet the costs of necessary medical services." 42 U.S.C. § 1396. In addition, the regulations promulgated pursuant to Title XIX provide that "the State may not arbitrarily deny or reduce the amount, duration, or scope of, such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition." 45 C.F.R. § 449.10(a)(5)(i).

We agree with the conclusion of the court in *Preterm* that limiting Medicaid assistance to life-threatening abortions "violate[s] the purposes of the Act and discriminate[s] in

---

(Footnote continued from preceding page)

state could not discriminate against funding medically necessary abortions under Medicaid. It did not reach the question whether the Hyde Amendment modified Title XIX, but held that even viewed as an appropriations measure, it relieved the states of the obligation of funding non-Hyde Amendment abortions because under Title XIX the states are obligated only to fund those procedures for which they will be reimbursed by the federal government.

a proscribed fashion'' (slip op. 9).[6] See also *White* v. *Beal*, 555 F. 2d 1146 (3d Cir. 1977); *Rush* v. *Parham*, 440 F. Supp. 383, 390-391 (N.D. Ga. 1977). The First Circuit was unanimous that the Medicaid Act requires participating states to provide "medically necessary'' abortions under their plans. Judge Bownes' point of disagreement with the majority was that in his view the Hyde Amendment does not permit participating states to limit necessary medical services for abortion to those set forth in that amendment. However, we agree with the conclusion of the majority in *Preterm* that the Hyde Amendment alters Title XIX in such a way as to allow states to limit funding to the categories of abortions specified in that amendment.

The Hyde Amendment is a provision which has been enacted in varying forms into the appropriations bills funding the Department of Health, Education and Welfare and the Labor Department for fiscal years 1977, 1978 and 1979. The fiscal 1978 and 1979 versions of it provide:

> "None of the funds contained in this Act shall be used to perform abortions except when the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest have been reported promptly to a law enforcement agency or public health service, or except in those instances where severe and long-lasting physical health

---

6. The Massachusetts law at issue in *Preterm* limited funding to abortions "necessary to prevent the death of the mother'' and to procedures "necessary for the proper treatment of the victims of forced rape or incest." (Slip op. 2.) That Massachusetts law is similar to but somewhat more liberal than the Illinois statute here at issue, which provides funding only when an abortion is "necessary for the preservation of the life of the woman."

> damage to the mother would result if the pregnancy were carried to term when so determined by two physicians." (See note 4 *supra*.)

Since, like the First Circuit, we have held that Title XIX prohibits discrimination in funding based on type of condition, the Hyde Amendment by singling out abortions for funding under only certain narrowly defined circumstances is in conflict with the substantive provisions of the Medicaid Act. It therefore becomes necessary to determine whether the Hyde Amendment was intended to amend the provisions of Title XIX or merely to prohibit the expenditure of federal funds. Under the latter interpretation, the states would be obligated to provide for medically necessary abortions for which federal funds would not be available.[7]

As indicated, we agree with Judge Coffin's opinion in *Preterm* and conclude that the Hyde Amendment did amend Title XIX. We are most reluctant to conclude that Congress has used an appropriations measure to effect such a change in the law, both because this reading enhances the likelihood of confusing and disruptive annual changes in the substantive law and because the Supreme Court has recently disapproved of so interpreting an appropriations bill.

---

7. The Hyde Amendment clearly mandates abortion funding in two categories of cases not covered by the Illinois law—cases of promptly reported rape or incest, and cases in which severe and long-lasting damage to the mother's physical health would result from continuing the pregnancy. Illinois is required to fund abortions falling into these categories under its Medicaid plan and is entitled to the usual federal reimbursement. The remaining question is whether Illinois must pursuant to Title XIX provide at its own expense abortions which are medically necessary but which do not qualify for federal reimbursement under the Hyde Amendment.

Tennessee Valley Authority v. *Hill*, —— U.S. ——, 46 LW 4673.

The Hyde Amendment on its face refers only to the use of federal funds. The plaintiffs have asserted that the language of the Hyde Amendment itself appears clear, so that it is—theoretically at least—unnecessary to consult the legislative history. As the preceding discussion indicates, however, what the states are required to do to comply with the requirements of Title XIX is not easily determined. Although we have concluded that the states may not exclude from coverage a whole category of medically necessary care, that conclusion is not necessarily obvious from the face of any single provision of the Medicaid Act. Because not all of the obligations of the states are clearly spelled out in that statute and because those obligations arise in the context of a plan for sharing expenses between the federal and state government,[8] it becomes appropriate to consult the legislative history of the Hyde Amendment to see what impact its provisions were intended to have on the substantive obligations of the participating states.

A fair-minded reading of the lengthy and often highly emotional floor debates in both houses of Congress during the yearly considerations of the Hyde Amendment compels the conclusion that Congress intended through this vehicle to alter the scope of Title XIX in regard to abortions. As the majority opinion in *Preterm* noted, a few Congressmen and Senators said that the amendment would simply restrict federal funds for abortions.[9] In context, however,

8. 42 U.S.C. § 1396b sets out the basic scheme for partial federal reimbursement of state expenditures under Medicaid.

9. Some of these comments appear at 123 Cong. Rec. H. 6086, 6090 (June 17, 1977); 123 Cong. Rec. H. 10826-10830 (Oct. 12, 1977); 123 Cong. Rec. S. 11039 (June 29, 1977).

even these remarks were apparently intended to distinguish between a prohibition on abortions (which would be unconstitutional under *Roe* v. *Wade, supra*), and a mere refusal to fund abortions. They do not appear to have been intended to suggest that state — but not federal — funds would be available. Moreover no one, whether supporting or opposing the Hyde Amendment, ever suggested that state funding would be required. To the contrary, the assumption was that when federal funds were withdrawn, the states, although free to continue to pay for abortions not falling within the parameters of the Hyde Amendment, would refuse to do so.[10]

In addition, a frequently reiterated belief was that taxpayers ought not to be compelled by the federal government to finance abortions which were repugnant to them on religious or moral grounds.[11] This concern would apply with at least equal force if the tax expenditures required by federal law came from the state rather than the federal treasury. Nor is there any suggestion in the Congressional debates that the Hyde Amendment would alter the basic

10. Comments revealing that assumption appear throughout the debates, but a sample of them can be found at 123 Cong. Rec. H. 6085 (Rep. Bauman); *id.* at 6086 (Rep. Stokes); *id.* at 6088 (Rep. Eckhardt); *id.* at 6089 (Reps. Fenwick and Spellman); *id.* at 6092 (Rep. Holtzman); *id.* at 6093 (Reps. Weiss and Allen) (June 17, 1977); 123 Cong. Rec. H. 10968 (Rep. Sears) (Oct. 13, 1977); 123 Cong. Rec. S. 18583-84 (Sen. Bayh); *id.* at 18589 (Sen. Packwood) (Nov. 3, 1977); 123 Cong. Rec. S. 13672 (Sen. Brooke) (Aug. 4, 1977); 123 Cong. Rec. S. 11040 (Sen. McGovern) (June 29, 1977).

11. Samples of these remarks appear at 123 Cong. Rec. H. 6085 (Rep. Obey); *id.* at 6088 (Rep. Rudd); *id.* at 6089 (Rep. Young) (June 17, 1977); 123 Cong. Rec. H. 10835 (Rep. Early) (Oct. 12, 1977); 123 Cong. Rec. S. 18584-18585 (Sen. Helms) (Nov. 3, 1977).

scheme of federal-state sharing of Medicaid expenses.[12] It is also clear that Congress was aware that its action could be construed as legislation via an appropriations bill,[13] and that this was not the preferred method of procedure.[14]

---

12. Plaintiffs have correctly noted that Medicaid and related statutes sometimes do require state expenditures unmatched by federal funds (Br. at 63-64, note). We have no doubt of Congress' authority to condition its expenditure of Medicaid funds on the states' expenditure of funds for related purposes. However, as plaintiffs' examples indicate, when Congress has imposed such conditions, it has done so explicitly and for the apparent purpose of encouraging the states to undertake programs Congress deemed to be desirable. Not only did Congress not explicitly shift the funding obligation to the states in the Hyde Amendment, but it also clearly did not intend to encourage abortions.

13. We do not rely on the fact that both the House and the Senate waived their rules against legislating in an appropriations bill (House Rule XXI(2); Standing Rules of the Senate, Rule 16.4) in concluding that the Hyde Amendment worked a substantive change in the law. Apparently both houses of Congress interpret those rules to mean that while a limitation of expenditures would be acceptable, any provision which imposed a duty on federal officials would go beyond a limitation and run afoul of the rules. See 123 Cong. Rec. H. 6082 (June 17, 1977). Because ascertaining when the conditions of the Hyde Amendment would be fulfilled was interpreted to impose additional duties on federal officials, only a flat ban on the use of funds for abortions was construed to be within the rules. It was in order to allow federal funds for abortions in certain limited circumstances that the rules were waived. Since a flat ban on abortion funding, although evidently within the procedural rules, would nevertheless conflict with our interpretation of Title XIX, the fact that the rules were waived, although relied upon by the defendants, is not helpful.

14. Early in the debate on the fiscal 1978 appropriations, Congressman Hyde spoke as follows:

(Footnote continued on next page)

Finally, the circumstances under which the Hyde Amendment was passed distinguish it from *Tennessee Valley Authority* v. *Hill, supra.* The problems the Supreme Court faced when asked to construe the appropriations for the TVA budget, including the Tellico Dam, as effecting a *pro tanto* repeal of the Endangered Species Act do not exist here. Unlike the situation in the *Hill* case, there is no quesiton here that Congress as a body was well aware of the implications of the Hyde Amendment and agreed to them. More importantly, *Hill* involved the question of when expenditures authorized under one Act should be interpreted to repeal the substantive provisions of an entirely inde-

---

> "Yesterday, remarks were made that it is unfortunate to burden an appropriation bill with complex issues, such as busing, abortion and the like. I certainly agree that it is very unfortunate. The problem is that there is no other vehicle that reaches this floor in which these complex issues can be involved. Constitutional amendments which prohibit abortions stay languishing in subcommittee, much less committee, and so the only vehicle where the Members may work their will, unfortunately, is an appropriation bill. I regret that. I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the HEW medicaid bill. A life is a life. The life of a little ghetto kid is just as important as the life of a rich person. And so we proceed in this bill."

123 Cong. Rec. H. 6083 (June 17, 1977). Subsequently, numerous other Congressmen and Senators, both opponents and proponents of the bill, indicated awareness that the amendment would have a substantive impact. See *e.g.,* 123 Cong. Rec. H. 6088 (Rep. Eckhardt); *id.* at 6090 (Rep. Mazzoli); *id.* at 6097 (Rep. Meyner) (June 17, 1977); 123 Cong. Rec. S. 11035 (Sen. Brooke) (June 29, 1977); 123 Cong. Rec. S. 19440, 19441 (Sen. Magnuson); *id.* at 19443 (Sen. Javits); *id.* at 19445 (Sen. Stennis) (Dec. 7, 1977).

pendent Act.[15] Here, in contrast, not only was the appropriations measure geared specifically to the substantive provisions of the affected Act, but the amendment was in the form of limiting previously authorized expenditures rather than authorizing arguably prohibited expenditures, as in *Hill*.

Under these circumstances, mindful that "[t]he doctrine disfavoring repeals * * * applies with even *greater* force when the claimed repeal rests solely upon an appropriations act,'"[16] we are nonetheless convinced by the overwhelming weight of the legislative history that Congress did intend to alter the substantive requirements of Title XIX by passing the Hyde Amendment.[17] Therefore Illinois is not re-

15. As the Supreme Court noted, implying such a repeal could wreak havoc with the legislative process.

> "When voting on appropriations measures, legislators are entitled to operate under the assumption that the funds will be devoted to purposes which are lawful and not for any purpose forbidden. Without such an assurance, every appropriations measure would be pregnant with prospects of altering substantive legislation, repealing by implication any prior statute which might prohibit the expenditure."

Tennessee Valley Authority v. *Hill*, —— U.S. at ——, 46 LW at 4683.

16. *Tennessee Valley Authority* v. *Hill*, —— U.S. at ——, 46 LW at 4683.

17. It is established that Congress has the power to legislate substantively in an appropriations Act. *United States* v. *Dickerson*, 310 U.S. 554. Moreover, when as here the substantive change is a prohibition against the use of funds for previously authorized purposes, the courts have been less hostile to modifications via appropriations bills. *Eisenberg* v. *Corning*, 179 F. 2d 275, 276 (D.C. Cir. 1949); *Friends of the Earth* v. *Armstrong*, 485 F. 2d 1, 9 (10th Cir. 1973), certiorari denied, 414 U.S. 1171; *City of Los Angeles* v. *Adams*, 556 F. 2d 40, 48-49 (D.C. Cir. 1977).

quired by Title XIX to fund abortions other than those covered by the Hyde Amendment.

As noted, the district court did not reach the constitutional arguments raised by the parties because it had statutory grounds for its decision. Because the constitutional issues were not considered below, and in light of the fact that our interpretation of the Hyde Amendment to modify the requirements of Title XIX may alter the constitutional considerations, it would be inappropriate for us to pass on them now. The parties should have a full opportunity to develop their positions and the district court to rule on them. *Singleton* v. *Wulff*, 428 U.S. 106, 120. Therefore, we remand the case for expedited consideration of the constitutional questions that remain open. This consideration should include, *inter alia*, whether the Hyde Amendment, by limiting funding for abortions to certain circumstances[18] even if such abortions are medically necessary, violates the Fifth Amendment in view of the facts that no other category of medically necessary care is subject to such constraints and that abortion has been recognized as a fundamental right. *Roe* v. *Wade*, *supra*.

On remand, the permanent injunction granted by the district court must be modified forthwith to require defendants to grant payments to plaintiff physicians and other recognized and legal medical providers for the rendition of medi-

18. The constraints imposed by the Hyde Amendment on medically necessary abortions which are not imposed on other kinds of medically necessary care include (1) a greater degree of potential harm from withholding treatment (the threatened damage in the case of an abortion must be "severe and long-lasting"), (2) the threatened harm must be physical, and (3) two doctors must make the determination of likely harm.

cal services to indigent pregnant women for those abortions fundable under the Hyde Amendment. The defendants have pointed out that the challenged Illinois law applies to medical care under fully state-funded plans as well as under Medicaid (Ill. Rev. Stat. ch. 23 §§ 6-1 and 7-1; General Assistance and Local Aid to the Medically Indigent, respectively). Therefore, they assert, since the Illinois statute has so far been determined only to contravene Title XIX as altered by the Hyde Amendment, enforcement of the Illinois statute should not be enjoined as it applies to purely state-funded plans. The plaintiffs urge us to find the statute non-severable, so that its application to purely state-funded plans falls with the federally funded portion.[19]

This presents a close question that necessitates interpreting what the Illinois General Assembly would likely have done had it been able to forsee the development of this case. [20] In a similar situation the Illinois Supreme Court has held a law non-severable (*Sperling* v. *County Officers Electoral Board,* 57 Ill. 2d 81 (1974), whereas in others it has not (*Vissering Mercantile Co.* v. *Annunzio,* 1 Ill. 2d 108 (1953); *People ex rel. Engle* v. *Kerner,* 32 Ill. 2d 212

19. The defendants suggest that we should not consider the severability issue since the district court did not articulate this ground for its decision. However, we may affirm a district court's ruling which is correct as a matter of law even though the proper ground was not expressed. Therefore cases cited by defendants to the effect that an appellate court will not consider a ground for reversal which was not presented to the district court are inapposite.

20. The Illinois Supreme Court has formulated the test for severability of provisions of a law as whether "it can be said that the General Assembly would not have passed the statute with the invalid portion eliminated." *People* ex rel. *Engle* v. *Kerner,* 32 Ill. 2d 212, 221-222 (1965).

(1965)). We have been told that the vast majority of publicly funded abortions would come under the Medicaid plan rather than the purely state plans. In these circumstances, it is not at all clear that the General Assembly would have imposed standards for funding from state plans which differ from the standards for Medicaid funding. The defendant State's official has informed us that the Illinois law "represents Illinois' understanding of Congressional purpose as reflected in the Hyde Amendments to federal welfare appropriations and the Supreme Court's delineation of the nature and extent of the qualified 'right' to abortion vis-a-vis the public funding issue * * *" (Br. 9).[21] Since the State itself has tied the challenged statute to the proper interpretation of what is required by Title XIX, evidently it intended that recipients of purely state funds be treated consistently with those who receive Medicaid funds.

In light of this history of the challenged law, and in view of the fact that the resolution of the constitutional issues will apply equally to the state-funded and the Medicaid-funded plans,[22] we conclude that the various provisions of the law should not be severed and that the modified injunction should apply to all publicly funded abortions.

21. When the Illinois law was passed, the version of the Hyde Amendment then in effect (fiscal year 1977) provided funds for abortions only when the life of the mother was endangered.

22. If the Hyde Amendment is determined to violate the guarantee of equal protection as it inheres in the Due Process clause of the Fifth Amendment, it appears likely that similar state action would violate the Fourteenth Amendment.

Vacated and remanded for further proceedings consistent herewith.[23]

A true Copy:

Teste:

.....
Clerk of the United States Court of Appeals for the Seventh Circuit

---

23. Our mandate shall issue this day.

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

Name of Presiding Judge, Honorable ALFRED Y. KIRKLAND.

Cause No. 77 C 4522.

Date—February 15, 1979.

Title of Cause—DAVID ZBARAZ, M.D., et al. v. ARTHUR F. QUERN.

Brief Statement of Motion—Mandate of the United States Court of Appeals for the Seventh Circuit.

Pursuant to the mandate of the Court of Appeals for the Seventh Circuit contained in its Judgment and Opinion of February 13, 1979, this Court hereby modifies its permanent injunction entered on May 15, 1978 to provide:

This Court hereby orders that defendant be permanently enjoined from:

(1) enforcing Ill. Rev. Stat. Supp. (1977) ch. 23, §§ 5-5, 6-1, 7-1 to deny payments under the Illinois medical assistance programs to plaintiffs Zbaraz, Motew, and any other recognized and legal medical providers, for the rendition of medical services to indigent pregnant women for: (a) abortions when the life of the mother would be endangered if the fetus were carried to term; (b) such medical procedures necessary for the victims of rape or incest, when such rape or incest have been reported promptly to a law enforcement agency or public health service; and (c) abortions in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians, or to deny such payments on behalf of any such indigent pregnant women for such abortions; (2) directing notice to any recognized and legal med-

ical providers, or to persons receiving assistance under the Illinois medical assistance programs, that the abortions and medical procedures described in ¶(1) are not, or will not be, a covered (reimbursable) service under the Illinois medical assistance programs.

The remainder of the permanent injunction of May 15, 1978 and the definitions contained therein remain in full force and effect with the exception of ¶ (d) [containing the definition of "therapeutic"] which is hereby deleted.

The parties are to appear for a status hearing at 9:30 a.m. on February 22, 1979 at which time procedures will be developed to enable expedited consideration of the constitutional questions which remain before this Court as a result of the judgment and opinion of the Seventh Circuit entered herein.

Alfred Y. Kirkland.

Alfred Y. Kirkland.

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

Name of Presiding Judge, Honorable ALFRED Y. KIRKLAND.

Cause No. 77 C 4522.

Date—February 22, 1979.

Title of Cause—DAVID ZBARAZ, M.D., et al. v. ARTHUR F. QUERN, et al.

Brief Statement of Motion—Certification to the Attorney General of the United States pursuant to 28 U.S.C. § 403(a).

Pursuant to 28 U.S.C. § 2403(a), this Court hereby certifies to the Attorney General of the United States that the constitutionality of an Act of Congress (specifically the fiscal years 1978 and 1979 version of the so-called "Hyde Amendment" first enacted as a rider to Fiscal Year 1977 Health, Education and Welfare appropriations bill [Section 209 of Pub. L. 95-205, 91 Stat. 1460 Dec. 9, 1977]) affecting the public interest is drawn into question in this lawsuit. The Attorney General is directed to notify this Court by March 8, 1979 whether the United States intends to seek permission to intervene herein for presentation of evidence and for argument on the question of constitutionality.

Alfred Y. Kirkland.

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

Name of Presiding Judge, Honorable ALFRED Y. KIRKLAND.

Cause No. 77 C 4522.

Date—March 8, 1979.

Title of Cause—DAVID ZBARAZ, M.D., et al. v. ARTHUR F. QUERN.

Brief Statement of Motion—Request of the United States for Permission to Intervene Pursuant to 28 U.S.C. § 2403(a) [contained in the letter of March 7, 1979] and revised briefing schedule on remaining issues.

The request of the United States for permission to intervene pursuant to 28 U.S.C. § 2403(a) [contained in a letter to this Court from Assistant Attorney General Babcock dated March 7, 1979] is granted.

Pursuant to the agreement of the parties, the simultaneous briefing schedule concerning the remaining constitutional issues in this case contained in this Court's Order of February 22, 1979 is hereby revised as follows:

> The parties are to submit briefs in support of their positions on the constitutional issues remaining by March 22, 1979; the parties are to file reply briefs to the briefs filed by opposing parties by March 29, 1979. The United States is subject to this briefing schedule. Filing of these reply briefs will conclude the briefing on these issues and this Court will give expedited consideration to these issues and will make any rulings necessary concerning these issues within a short period of time thereafter.

The time limits contained in this briefing schedule will be strictly enforced by this Court.

Alfred Y. Kirkland.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DAVID ZBARAZ, M.D., et al.,
Plaintiffs,
vs.
ARTHUR F. QUERN, etc.,
Defendant.
No. 77 C 4522

MEMORANDUM OPINION

Plaintiffs brought this class action[1] under 42 U.S.C. Section 1983 to enjoin enforcement of a 1977 Illinois statute withdrawing medical assistance funding for all abortions except those "necessary for the preservation of the life of the pregnant woman." P.A. 80-1091, Ill. Rev. Stat. Supp. (1977) ch. 23, Sections 5-5, 6-1, 7-1.[2] Plaintiffs are two doc-

---

1. The classes certified by the district court consist of (1) all pregnant women eligible for the Illinois medical assistance programs for whom an abortion is medically necessary but not necessary for the preservation of their lives and who wish such abortion performed, and (2) all Illinois physicians who are certified to obtain reimbursement for necessary medical services rendered to, and who perform medically necessary abortions for, persons eligible for the Illinois medical assistance programs.

2. Those sections provide, in relevant part:

Section 5-5. The Illinois Department, by rule, shall determine the quantity and quality of the medical assistance for which payment will be authorized, and the

(Footnote continued on next page)

tors who perform medically necessary, but not necessarily life-preserving abortions for indigent women; the Chicago Welfare Rights Organization, whose members include women dependent on Illinois medical assistance benefits; and Jane Doe, an indigent woman for whom an abortion is medically necessary but not necessary for the preservation

---

(Footnote continued from preceding page)

> medical services to be provided, which may include all or part of the following: . . . but not including abortions, or induced miscarriages or premature births, unless, in the opinion of the physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.
>
> Section 6-1. Nothing in this Article shall be construed to permit the granting of financial aid where the purpose of such aid is to obtain an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.
>
> Section 7-1. Aid in meeting the costs of necessary medical, dental, hospital, boarding or nursing care, . . . except where such aid is for the purpose of obtaining an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a viable child and such procedure is necessary for the health of the mother or her unborn child.

of her life. Defendant Arthur Quern is the Director of the Illinois Department of Public Aid, the state agency responsible for administering Illinois medical assistance programs. Intervenor-defendants include two doctors and the United States.

The complaint alleged that P.A. 80-1091 violated plaintiffs' rights under the Social Security Act, 42 U.S.C. Section 1396 et seq., and the Ninth and Fourteenth Amendments to the United States Constitution. Plaintiffs sought both declaratory and injunctive relief. The case was originally assigned to Judge Kirkland. On December 21, 1977, he ordered the proceedings stayed pending an interpretation of P.A. 80-1091 by an Illinois state court. Reasoning that the Illinois statute could be construed to be consistent with the Social Security Act, Judge Kirkland decided the exercise of federal jurisdiction at the time would be imprudent. He therefore merely entered and continued plaintiffs' motion for preliminary relief. (Memorandum Opinion and Order of December 21, 1977, at 3-5).

Plaintiffs appealed and the Seventh Circuit reversed. *Zbaraz* v. *Quern,* 572 F. 2d 582 (7th Cir. 1978). In its ruling, the Court of Appeals declined to decide the merits of plaintiffs' motion for a temporary restraining order and/or preliminary injunction. Instead, the court remanded the case to the district court for expeditious consideration of the question of preliminary relief.

On remand, Judge Kirkland held that by failing to cover "medically necessary" abortions, P.A. 80-1091 violated the Social Security Act and its implementing regulations. The court reasoned that Illinois' funding of only "life-preserving" abortions fell short of its responsibilities under Title XIX to establish "reasonable standards . . . for determining . . . the extent of medical assistance under the plans which . . . are consistent with the objectives of [the Medi-

caid program]," 42 U.S.C. Section 1396(a)(17). The court noted that the prime objective of Medicaid is to "furnish medical assistance [to eligible persons] to meet the costs of necessary medical services." 42 U.S.C. Section 1396. (Memorandum Opinion of May 15, 1978, at 8-11).

In his decision, Judge Kirkland also considered the impact of the Hyde Amendment on a state's responsibilities under Title XIX. The Hyde Amendment, first enacted as a rider to the 1977 fiscal year budget for the Department of Health, Education and Welfare, provides:

> None of the funds provided for in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

Section 210 of Pub. L. 95-480; 92 Stat. 1586, Oct. 18, 1978. Judge Kirkland interpreted the Hyde Amendment as a prohibition on the use of federal funds rather than a substantive amendment to the Social Security Act. A state's obligations under Title XIX to fund medically necessary abortions, Judge Kirkland thus concluded, survived passage of the Hyde Amendment. Judge Kirkland issued a permanent injunction restraining defendants from enforcing P.A. 80-1091 to deny payments under the Illinois medical assistance programs for therapeutic abortions. (Memorandum Opinion of May 15, 1978, at 11-12).

Defendants appealed and again the Seventh Circuit reversed. *Zbaraz* v. *Quern*, —— F. 2d ——, No. 78-1669, February 13, 1979. Following the lead of the First Circuit

Court of Appeals in *Preterm, Inc.* v. *Dukakis*, —— F. 2d —— (1st Cir. Nos. 78-1324, 78-1325, and 78-1326, decided January 15, 1979), the court held that the Hyde Amendment, by singling out abortions as a category of care which would be funded only under certain narrow circumstances, conflicted unavoidably with Title XIX. Despite its seemingly unambiguous language and its location in an appropriations measure, therefore, the Seventh Circuit concluded that the Hyde Amendment was not just a limitation on the use of federal funds, but an amendment to Title XIX as well. (Slip Op. at 6). Since the Amendment removed all but a narrow category of abortions from Medicaid coverage, it effectively permitted states also to withhold funds from non-Hyde Amendment abortions. (Slip Op. at 10)

The Court of Appeals recognized the constitutional questions raised by its holding[3] and remanded the case to the

---

3. The Seventh Circuit included in its mandate a directive to pass on the constitutionality of the Hyde Amendment, even though plaintiffs attack only the legality of an Illinois statute. After remand, therefore, the United States was permitted to intervene pursuant to 28 U.S.C. Section 2403(a). In its brief in support of the Hyde Amendment, the United States suggested that the Seventh Circuit "viewed the federal and state legislation as inextricably intertwined." (Brief for the United States, at 4). Although we are not persuaded that the federal and state enactments are inseparable and would hesitate to inject into the proceeding the issue of the constitutionality of a law not directly under attack by plaintiffs, we are obviously constrained to obey the Seventh Circuit's mandate. Therefore, while our discussion of the constitutional questions will address only the Illinois statute, the same analysis applies to the Hyde Amendment and the relief

(Footnote continued on next page)

district court which directions to modify the permanent injunction and to decide the constitutional questions.[4] (Slip Op. at 11).

(Footnote continued from preceding page)

granted will encompass both laws. We note that although the Fifth Amendment does not contain an express Equal Protection Clause, its Due Process Clause has been construed to incorporate equal protection guarantees. *Weinberger* v. *Salfi*, 422 U.S. 749, 770 (1975); *Richardson* v. *Belcher*, 404 U.S. 78, 81 (1971).

4. The Seventh Circuit instructed the district court to determine whether the withholding of funds for "medically necessary" abortions violated the constitution. (Slip Op. at 11). Prior to P.A. 80-1091, Illinois funded "therapeutic" abortions, defined as "medically necessary or medically indicated according to the professional medical judgment of a licensed physician in Illinois, exercised in light of all factors affecting a woman's health." State of Illinois Dept. of Public Aid —Medical Assistance Program Handbook for Physicians, January, 1976, A-204. The Seventh Circuit adopted this definition of "therapeutic" without addressing the question of whether it was broader than "medically necessary." Judge Kirkland treated the two as synonymous. (See Order of May 15, 1978, at 10). Whether the terms "medically necessary" and "therapeutic" are coextensive is a question that is not merely of academic significance. If, by attacking the constitutionality of P.A. 80-1091, plaintiffs are advocating a return to the status quo ante, then presumably a decision in their favor would result in the funding of all "therapeutic" abortions. But as we read the complaint, plaintiffs seek funding for "medically necessary" abortions, whether or not that is broad enough to include

(Footnote continued on next page)

Pursuant to the Seventh Circuit's mandate, Judge Kirkland modified his permanent injunction to require Illinois to fund under its medical assistance programs abortions which fall within the scope of the Hyde Amendment exceptions. (Minute Order entered February 15, 1979). Judge Kirkland set a briefing schedule, but then determined that for medical reasons he would be unable to give the case the "expeditious consideration" ordered by the Seventh Circuit. The case was reassigned to us on April 18, 1979.

Now pending are the parties' cross-motions for summary judgment and plaintiffs' motion for a temporary restraining order. The latter motion is a response by plaintiffs to the announced intention of the Illinois Department of Public Aid to deny reimbursements for all abortions except those which it is required to fund by Judge Kirkland's modified injunction—that is, abortions still covered under the Hyde Amendment—beginning May 1. For the reasons which follow, we will grant partial summary judgment for both plaintiffs and defendants.

Although plaintiffs raised a number of constitutional issues in their complaint,[5] their principal argument is that,

---

(Footnote continued from preceding page)

all "therapeutic" abortions. This reading harmonizes with plaintiffs' theory of the case—that by funding "medically necessary" operations other than abortions, Illinois is denying plaintiffs equal protection of the laws. Accordingly, we will treat the action as an attack on Illinois' failure to fund "medically necessary" abortions.

5. Plaintiffs also alleged that P.A. 80-1091 violated the Establishment and Free Exercise Clauses of the First Amendment to the Constitution made applicable to the states by the Fourteenth Amendment, and the

(Footnote continued on next page)

by imposing restrictions on the public funding of medically necessary abortions which are not imposed on other medically necessary operations, P.A. 80-1091 violates their rights to equal protection of the laws guaranteed by the Fourteenth Amendment to the United States Constitution.[6] The framework for analyzing claims of alleged deprivations of equal protection is now well-established:

> We must decide, first, whether [the statute] operates to the disadvantage of some suspect class or impinges upon a fundamental right explicitly or implicitly protected by the Constitution, thereby requiring strict judicial scrutiny. . . . If not, the [legislative] scheme must still be examined to determine whether it rationally furthers some legitimate, articulated state purpose and therefore does not constitute an invidious discrimination. . . .

San Antonio School District v. *Rodriguez,* 411 U.S. 1, 17 (1973).

(Footnote continued from preceding page)

Due Process Clause of the Fourteenth Amendment. (Complaint, par. 22(d)). Plaintiffs' due process claim rests on their argument that the statute disrupts "the carefully constructed balance of constitutional interests Wade and its progency established." (Memorandum in Support of Motion for Summary Judgment, at 22). We believe this contention is subsumed under their equal protection challenge, and we will not treat it separately in this opinion.

6. Plaintiffs have also challenged as unconstitutional the reporting requirement for rape victims. None of the plaintiffs, however, have asserted any personal stake in the determination of this issue. Where, as here, a statute contains separable provisions, a person may challenge only those provisions which operate to injure him, and may not challenge those provisions that cause him no harm. *See Bell* v. *Hongisto,* 501 F. 2d 346 (9th Cir. 1974), *cert. denied* 420 U.S. 962 (1975).

Relying on *Roe* v. *Wade,* 410 U.S. 113 (1973) and subsequent abortion decisions, plaintiffs contend that strict judicial scrutiny is appropriate here because a fundamental right is implicated. In *Roe,* the Supreme Court struck down a Texas statute that made criminal the performance or procurement of an abortion unnecessary to save a mother's life. The Texas legislation was constitutionally infirm, the Court held, because for every stage of a woman's pregnancy, it subordinated the woman's right to privacy, a right which "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy," to the state's interests in preserving maternal health and promoting fetal life. 410 U.S. at 153. The Court emphasized, however, that although the right of personal privacy "includes the abortion decision . . . this right is not unqualified and must be considered against important state interests in regulation." 410 U.S. at 154. *See also, Doe* v. *Bolton,* 410 U.S. 179, 189 (1973).

Thus, the right recognized in *Roe* is not an affirmative right to an abortion, but is simply a right to make and effectuate the abortion decision, at least in the first trimester of pregnancy, free from governmental regulation. During the second trimester, a state may restrict the effectuation of that decision only in a manner that reasonably promotes the health of the mother. After the fetus has achieved viability, a state may constitutionally proscribe abortion "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." 410 U.S. at 164, 165.

Plaintiffs argue here that by erecting a "substantial impediment to poor women's obtaining medically necessary abortions," P.A. 80-1091 restricts the effectuation of their decision to "bear or beget a child," and thereby triggers strict scrutiny. We believe this argument has been explicitly

rejected by the United States Supreme Court in *Maher* v. *Roe,* 432 U.S. 464, 470 (1977), and is therefore foreclosed to plaintiffs here. In *Maher,* the Supreme Court held that the Constitution does not require a state participating in Social Security to pay for nontherapeutic abortions although it pays the expenses of childbirth. Plaintiffs in *Maher* argued that the Connecticut medical assistance scheme infringed upon their fundamental rights as announced in *Roe* v. *Wade.* Rejecting this contention, the Court observed:

> [Roe] implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds.
>
> * * * * *
>
> The indigency that may make it difficult—and in some cases, impossible—for some women to have abortions is neither created nor in any way affected by the Connecticut regulation.
>
> * * * * *
>
> There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy.

432 U.S. at 474, 475.

As in *Maher,* plaintiffs here will encounter difficulty effectuating their decision to terminate a pregnancy not because of any state regulation, but because of their indigency. *Maher* compels the conclusion, therefore, that P.A. 80-1091 impinges upon no fundamental right and should not be subjected to strict judicial scrutiny.[7]

---

7. Plaintiffs apparently do not argue that P.A. 80-1091 creates a "suspect classification." This argument

(Footnote continued on next page)

In further support of their argument that strict scrutiny is appropriate here, plaintiffs analogize to the case of *Shapiro* v. *Thompson,* 394 U.S. 618 (1969). There the Supreme Court declared unconstitutional various state statutory provisions which denied welfare assistance to persons who had not satisfied one year residency requirements, but who were otherwise eligible for welfare benefits. The Court reasoned that by treating indigents who had resided in the state less than a year differently from those who had satisfied the residency requirement, the state was penalizing indigents' rights to migrate, or travel interstate. Since the right to travel interstate was deemed "fundamental," the Court subjected the statutes to strict scrutiny. Finding no compeling justification for treating one year residents differently, the Court concluded that the statutes were unconstitutional. The Court noted that if the purpose of the provisions was to deter migration, or prevent an influx of indigents seeking higher welfare benefits, those purposes were "constitutionally impermissible." 394 U.S. at 631.

In this case, plaintiffs contend that Illinois is penalizing indigent women who desire to exercise their right to effectuate the abortion decision, We believe that again *Maher* disposes of this argument. As the *Maher* Court observed:

> [T]he claim here is that the State "penalizes" the women's decision to have an abortion by refusing to pay for it. Shapiro and Maricopa County did not hold that States would penalize the right to travel interstate by refusing to pay the bus fares of the indigent travelers. We find no support in the right-to-

---

(Footnote continued from preceding page)

would also be unavailing under *Maher.* There the Supreme Court stated that, "This Court has never held that financial need alone identifies a suspect class for purposes of Equal Protection." 432 U.S. at 470.

> travel cases for the view that Connecticut must show a compelling interest for its decision not to fund elective abortions.

432 U.S. n. 8 at 475. Since there is no fundamental right to a publicly funded abortion, the analogy to *Shapiro* fails, "penalty analysis" does not apply, and strict scrutiny is unnecessary.

Our determination that P.A. 80-1091 should not be subjected to strict judicial scrutiny, however, does not resolve the question of the statute's constitutionality. Whenever a statute treats different classes of individuals differently, that legislative line-drawing is properly the subject of judicial examination. *San Antonio School District* v. *Rodriguez,* 411 U.S. 1, 17 (1973). Here, since indigent women in medical need of abortions are treated differently than indigent women in medical need of other surgical procedures, we must subject the statute to the rational relationship test. Under this test, the statute passes constitutional muster only if we can conclude that the legislative classification rationally furthers some legitimate, articulated state purpose. *Id.* As the Supreme Court observed in *Maher,* in applying the identical test,

> The Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents. But when a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations.

432 U.S. at 469-70.

The various defendants have suggested that the statute is supported by the state's legitimate interests in "fiscal frugality" and in protecting fetal life through the encouragement of childbirth. While the allocation of limited public

funds is a legitimate interest of the state, *see generally, Dandridge* v. *Williams,* 397 U.S. 471, 487 (1970), we do not believe that the Illinois funding policy is rationally related to this purpose. In fact, the record in this case supports the contrary conclusion that the costs of prenatal care, childbirth and postpartum care are substantially higher than the cost of abortions.[8] All of the births in question involve women who have encountered complications in their pregnancies, which would presumably increase the cost of needed medical care. Of course, if the newborn child then receives public aid, the cost diffential is even greater. The Illinois General Assembly was well aware of these potential cost differences, as shown by the remarks of Senator Lemke, Senate sponsor of P.A. 80-1091:

> My people don't want abortion being performed with their money. If it costs them more to support these children after they're born, they will pay that money gladly as long as it's properly used.

Debate on H.B. 333, Illinois Senate, June 27, 1977. In short, P.A. 80-1091 was not, and could not be, motivated by economic concerns.

The other state interest offered in support of the state classification is the protection of the fetus through the encouragement of childbirth. The Supreme Court has recognized this as a legitimate state interest in some circumstances. *See Maher* v. *Roe,* 432 U.S. 464 (1977); *Poelker* v. *Doe,* 432 U.S. 519, (1977); *Roe* v. *Wade,* 410 U.S. 113 (1973). In *Maher,* the Court held that Connecticut could

---

8. Plaintiffs have produced convincing statistical evidence that the average State payment for an abortion is approximately $145.00, compared to an average cost to the State of $1,372.00 for funding a childbirth.

encourage "normal childbirth" by subsidizing the costs incident to childbirth while, at the same time, refusing to expend funds for *nontherapeutic* (purely elective) abortions. The Connecticut statute differed from the Illinois statute challenged here because it provided the funding of "medically necessary" abortions. We believe this distinction to be crucial to the determination of this case.

Under *Maher,* a state may legitimately prefer childbirth to an elective abortion. We do not believe, however, that a state has a legitimate interest in promoting the life of a non-viable fetus in a women for whom an abortion is medically necessary.[9] This approach, which recognizes

---

9. *Poelker* v. *Doe,* 432 U.S. 519 (1977), does not require a contrary result. There a woman challenged a city policy that prohibited the performance of abortions in city-owned hospitals for reasons other than to save the mother from grave physiological injury or death. When plaintiff was examined by hospital physicians, however, physicians could not find "*any* medical reasons to justify an abortion," such as "severe sickness of the patient." 515 F. 2d at 543. Accordingly, the Court of Appeals treated the case as one where plaintiff demanded a "nontherapeutic" abortion. 515 F. 2d at 545. When the case was appealed, the Supreme Court adopted the lower court's characterization of the issue in upholding the city policy. 432 U.S. at 521. Because the Court viewed plaintiff's argument as an attack on the city's withholding of city-owned facilities for elective, or nontherapeutic abortions, *Maher* of course controlled. In this case, the plaintiff class is defined in terms of indigent women for whom abortions are medically necessary. We agree with plaintiffs that the Supreme Court could not have intended in its per curiam *Poelker* decision to obliterate the distinction it

(Footnote continued on next page)

that the fetus is being carried within a living, human being, is consistent with Supreme Court decisions which suggest that the interest in the fetus cannot be isolated from the interest in the health of the mother. *See generally, Roe* v. *Wade,* 410 U.S. at 159; *Colautti* v. *Franklin,* 99 S. Ct. 675, 688 (1979).[10]

As a consequence of the state's viewing the fetus apart from the mother, the mother may be subjected to considerable risk of severe medical problems, which may even result in her death. Under the Hyde Amendment standard, a doctor may not certify a woman as being elegible for a publicly funded abortion except where "the life of the mother would be endangered . . . or . . . where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term. . . ." Most health problems associated with pregnancy would not be covered by this language, (Affidavit of Dr. Oren Richard Depp, p. 10, affidavit of Dr. David Zbaraz), and those that would be covered would often not be apparent until

---

(Footnote continued from preceding page)

had carefully drawn in *Maher* between medically necessary and nontherapeutic abortions. We note, however, that at least two district courts have given *Poelker* v. *Doe* the sweeping interpretation we reject here. *Doe* v. *Mundy,* 441 F. Supp. 447, 451-52 (E.D. Wis. 1977); *Frieman* v. *Walsh,* No. 77-4171-CV-C (W.D. Mo. filed January 26, 1979).

10. *Colautti* v. *Franklin,* 99 S. Ct. 675 (1979) involved a challenge to a Pennsylvania statute which subjected a physician who performed an abortion to potential criminal liability if he failed to utilize a statutorily prescribed technique when the fetus was "viable," or when there was sufficient reason to believe that the fetus was viable. The Court stated:

(Footnote continued on next page)

the later stages of pregnancy, when an abortion is more dangerous to the mother (Affidavit of Dr. Depp, pp. 4-5). At the earlier stages of pregnancy, and even at the later stages, doctors are usually unable to determine the degree of injury which may result from a particular medical condition (*Id.* at 4). The effect of the new criteria, then, will be to increase substantially maternal morbidity and mortality among indigent pregnant women (*Id.* at 12).[11]

(Footnote continued from preceding page)

> Moreover, the second part of the standard directs the physician to employ the abortion technique best suited to fetal surival "so long as a different technique would not be *necessary* in order to preserve the life or health of the mother" (emphasis supplied). In this context, the word "necessary" suggests that a particular technique must be indispensable to the woman's life or health—not merely desirable—before it may be adopted.
>
> Consequently, it is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a "trade-off" between the woman's health and additional percentage points of fetal survival. Serious ethical and constitutional difficulties, that we do not address, lurk behind this ambiguity.

11. Moreover, the new Illinois criteria completely ignore the very serious threats to an indigent pregnant woman's psychological or psychiatric health that may make an abortion medically necessary. One doctor has estimated that approximately 15 per cent of a representative group of women desiring abortions have a psychiatric need for an abortion. He also concluded that indigent women are more likely than are non-indigent women to suffer adverse mental health consequences from unwanted pregnancy. (Affidavit of Dr. Peter Barglow, at 4, 6).

We cannot hold that a state has a legitimate interest in preserving the life of a non-viable fetus at the cost of increased maternal morbidity and mortality among indigent pregnant women. In *Memorial Hospital* v. *Maricopa County,* 415 U.S. 250 (1974), the Supreme Court was faced with a challenge to an Arizona statute which required one year's residence in a county as a condition to receiving non-emergency hospitalization or medical care at the county's expense. In striking down the state statute as infringing on the fundamental right to interstate travel, the Supreme Court stated:

> Evaro was an indigent person who *required* continued medical care for the preservation of his health and well being . . . , even if he did not require immediate emergency care. The State could not deny Evaro just because, although gasping for breath, he was not in immediate danger of stopping breathing altogether. To allow a serious illness to go untreated until it requires emergency hospitalization is to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health. Cancer, heart disease, or respiratory illness, if untreated for a year, may become all but irreversible paths to pain, disability, and even loss of life. The denial of medical care is all the more *cruel* in this context, falling as it does on indigents who are often without the means to obtain alternative treatment.

415 U.S. at 260-61 (emphasis added). Like the Arizona statute in *Maricopa County,* the Illinois statute as modified will deny needed medical aid to indigent mothers until the point when a doctor is able to certify that the mother's life is endangered or when severe and long-lasting physical health damage[12] appears certain to occur. Action that

---

12. The affidavits submitted by plaintiffs give many examples of medical conditions which would not be

(Footnote continued on next page)

the Supreme Court characterized as "cruel" in *Maricopa County* can hardly be considered as a permissible side effect of a "legitimate" state interest in the present case.

As the Supreme Court recognized in *Roe,* however, the state's interest in promoting fetal life grows with the length of the pregnancy. At any point in the pregnancy term, the strength of the state's interest can only be determined by balancing "the relative weight of the respective interests involved." *Roe* v. *Wade,* 410 U.S. at 165.

(Footnote continued from preceding page)

covered by the new Illinois standards, but which could pose a great threat to the safety of the mother. For example, the affidavit of Dr. David Zbaraz states, at pp. 5-6:

> The lack of certainty about predictions extends to even the most serious of potentially life-threatening conditions. For example, women with sickle cell disease have a 25 per cent probability of going into sickle cell crisis an dying as a result of pregnancy. (The normal mortality rate is 20 per 100,000). Because of this extra-ordinarily high mortality rate, abortions for women with sickle cell disease are almost universally acknowledged to be "medically necessary." I would thus actively counsel such women to have abortions, unless they expressed a very strong desire to have the child. Yet it simply cannot be known, however careful her care and physician's monitoring, whether a particular patient will go into crisis, or whether the state of her disease will remain unaffected by pregnancy. It would not be proper medical care to wait for such an actual threat before terminating the pregnancy, if the patient did not want to incur the risk. Yet the Illinois standard, by requiring certainty about the outcome of a pregnancy, does not comprehend this inherent uncertainty in medical judgment prior to the onset of actual health crises.

After the point of viability, for instance, that interest is regarded as "compelling," and justifies the proscription of abortion, except when it is necessary to preserve the life or health of the mother. 410 U.S. at 164.

Similarly, the state's interest in promoting the life of a fetus carried in a woman for whom an abortion is medically necessary is not constant. For the reasons just discussed, a pregnant woman's interest in her health so outweighs any possible state interest in the life of a non-viable fetus that, for a woman medically in need of an abortion, the state's interest is not legitimate. At the point of viability, however, "the relative weights of the respective interests involved" shift, thereby legitimizing the state's interest. After that point, therefore, we believe a state may withhold funding for medically necessary abortions that are not life-preserving, even though it funds all other medically necessary operations. We thus conclude that, as it applies to the abortion of a viable fetus, P.A. 80-1091 (as modifed by court order) is constitutional.

We recognize that, as with any standard that relies on the judgment of the individual administering it, "medical necessity" may be subject to deliberate misinterpretation and abuse. Some would argue that unscrupulous physicians, with the active encouragement of their indigent patients, will transform our decison into a *de facto* order that the state fund purely elective abortions. Such a result would, of course, be squarely contrary to the Supreme Court's *Maher* decison. Nonetheless, we believe the inherent elasticity of the standard we adopt today will pose no greater problem to the state's adminstration of its medical assistance programs than it did under the funding scheme that preceded P.A. 80-1091. Furthermore, we are encouraged by affidavits submitted by respected members of the medical professions that suggest that the percentage of abor-

tions any physican would deem "medically necessary" may be as low as one fifth of the representative cases in which a pregnant woman desires an abortion. ((Affidavit of Dr. Oren Depp, at 7). Finally, we note that providers of services under Illinois medical assistance programs are subject to civil and criminal penalties for filing false Medicaid reimbursement reports. 42 U.S.C. Section 1396h; Ill. Rev. Stat. ch. 23, Sections 12-15, 12-15.1.

CONCLUSION

We hold that the Hyde Amendment and P.A. 80-1091 are unconstitutional as applied to medically necessary abortions prior to the point of fetal viability. All parties are to appear on Monday, April 30, 1979, at 9:30 a.m. to discuss the problems of relief and notice. Plaintiffs are to prepare an appropriate judgment order and order granting injunctive relief for submission to the court on Monday, April 30, 1979.

DATED: April 29, 1978.

ENTER:

JOHN F. GRADY,
United States District Judge.

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

Name of Presiding Judge, Honorable JOHN F. GRADY.

Cause No. 77 C 4522.

Date—April 30, 1979.

Title of Cause—ZBARAZ v. QUERN, and WILLIAMS and DIAMOND, and the UNITED STATES.

Brief Statement of Motion—Motion for Stay.

Motion by Intervening Defendants for stay pending final outcome of this case pending appeal is denied.

John F. Grady.

UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

Name of Presiding Judge, Honorable JOHN F. GRADY.

Cause No. 77 C 4522.

Date—April 30, 1979.

Title of Cause—ZBARAZ et al v. QUERN, etc. et al.

Hearing held on proposed injunction order. Motion of all defendants for stay pending appeal, denied. Motion by defendant Quern, to require federal reimbursement etc., is entered and taken under advisement.

Enter Final Judgment and Order—(Draft).

John F. Grady.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DAVID ZBARAZ, M.D., et al., *Plaintiffs,* vs. ARTHUR F. QUERN, et al., *Defendants.*	No. 77 C 4522

FINAL JUDGMENT AND ORDER

On April 27, 1979, this Court issued a Memorandum Opinion which, *inter alia,* held Illinois' intended policy of denying reimbursement for all abortions under its medical assistance programs except those which it is required to fund under the District Court's modified injunction of February 15, 1979, unconstitutional as applied to medically necessary abortions performed prior to fetal viability. The District Court's previous May 15, 1978 Judgment and its June 13, 1978 Judgment, as modified by this February 15, 1975 Order, remain in force. But this Court directed plaintiffs to prepare an appropriate judgment order and order granting injunctive relief incident to the April 27, 1979 Memorandum Opinion for submission on April 30, 1979. Plaintiffs have done so. This Court has considered plaintiffs' proposed Decree, and now hereby ORDERS, ADJUDGES AND DECREES THAT:

1. This Court has jurisdiction over this case under 28 U.S.C. §§ 1343(3) and (4).

2. As used in this Judgment and Order, the following terms have the meanings indicated—

(a) "Recognized and legal medical providers" means all persons or institutions in Illinois who are certified to obtain reimbursement for medical services under the Illinois medical assistance programs;

(b) "Illinois medical assistance programs" means the Medicaid, state-funded General Assistance and Aid to the Medically Indigent programs, established pursuant to Ill. Rev. Stat., ch. 23, Arts. V-VII;

(c) "Indigent pregnant women" means pregnant women eligible for assistance under the Illinois medical assistance programs;

(d) "Medically necessary" as modifying "abortion" means an abortion which is necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in light of all factors relevant to her health;

(e) "Illinois' restrictive abortion funding policy" means the policy Illinois adopted pursuant to P.A. 80-1091, Ill. Rev. Stat. Supp. (1977), ch. 23, §§ 5-5, 6-1, 7-1, as modified by the District Court Order of February 15, 1979, and as described in the notices attached hereto as Exhibits A and B;

(f) "Fetal viability" means the point during pregnancy at which, in the professional judgment of a licensed physician in Illinois, a fetus is potentially able to live outside the mother's womb, albeit with artificial aid, such that there is a potentiality for meaning life, not merely momentary survival.

3. There are two plaintiff classes herein, certified pursuant to F.R.C.P. 23(a) and (b)(2). They consist of:

(a) all pregnant women eligible for the Illinois medical assistance programs for whom an abortion is medically necessary but not necessary for the preservation of their lives and who wish such abortion performed, and

(b) all Illinois physicians who are certified to obtain reimbursement for necessary medical services rendered to, and who perform medically necessary abortions for, persons eligible for the Illinois medical assistance programs.

4. Partial summary judgment is granted to both plaintiffs and defendants, as follows—

(a) Partial summary judgment is granted to plaintiffs that:

(i) Illinois' restrictive abortion funding policy and P.A. 80-1091, Ill. Rev. Stat. Supp. (1977), ch. 23, §§ 5-5, 6-1, 7-1, as applied by Illinois to deny funding, under the Illinois medical assistance programs, for medically necessary abortions performed prior to fetal viability, violate the equal protection clause of the Fourteenth Amendment to the United States Constitution;

(ii) The Hyde Amendment [Pub. L. 95-480, § 210, 92 Stat. 1586 (1978)], as construed by the 7th Circuit in *Zbaraz* v. *Quern,* —— F. 2d —— (Feb. 13, 1979) to permit Illinois to deny funding, under its Medical Assistance ("Medicaid") Program [Ill. Rev. Stat. ch. 23, Art. V; 42 U.S.C. §§ 1396ff.] for any medically necessary abortion performed prior to fetal viability, violates the Fifth Amendment to the United States Constitution.

(b) Partial summary judgment is granted to defendants that:

(i) Illinois' restrictive abortion funding policy and P.A. 80-1091, Ill. Rev. Stat. Supp. (1977), ch. 23, §§ 5-5, 6-1, 7-1, as applied by Illinois to deny funding under the Illinois medical assistance pro-

grams, for medically necessary abortions performed after fetal viability, do not violate the equal protection clause of the Fourteenth Amendment to the United States Constitution.

(ii) The Hyde Amendment [Pub. L. 95-480, § 210, 92 Stat. 1586 (1978)], as construed by the 7th Circuit in *Zbaraz* v. *Quern,* —— F. 2d —— (Feb. 13, 1979) to permit Illinois to deny funding, under its Medical Assistance ("Medicaid") Program [Ill. Rev. Stat. ch. 23, Art. V; 42 U.S.C. §§ 1396ff.] for any medically necessary abortion performed after fetal viability, does not violate the Fifth Amendment to the United States Constitution.

5. Illinois' restrictive abortion funding policy and P.A. 80-1091, Ill. Rev. Stat. Supp. (1977), ch. 23, §§ 5-5, 6-1, 7-1, as applied to deny funding, under the Illinois Medical assistance programs, for medically necessary abortions performed prior to fetal viability, are, pursuant to 28 U.S.C. § 2201, declared to violate the equal protection clause of the Fourteenth Amendment to the United States Constitution. The Hyde Amendment [Pub. L. 95-480, § 210, 92 Stat. 1586 (1978)], as construed by the 7th Circuit in *Zbaraz* v. *Quern,* —— F. 2d —— (Feb. 13, 1979) to permit Illinois to deny funding, under its Medical Assistance ("Medicaid") Program [Ill. Rev. Stat. ch. 23, Art. V; 42 U.S.C. §§ 1396ff.] for any medically necessary abortion performed prior to fetal viability, is, pursuant to 28 U.S.C. § 2201, declared to violate the Fifth Amendment to the United States Constitution.

6. Defendant Arthur F. Quern, his agents, employees and all persons in active concert with him are permanently enjoined from—

(a) enforcing Illinois' restrictive funding policy and P.A. 80-1091, Ill. Rev. Stat. Supp. (1977), ch. 23, §§ 5-5, 6-1, 7-1, to deny payments under the Illinois medical assistance programs to any recognized and legal providers for the rendition of medical services to indigent pregnant women for medically necessary abortions performed prior to fetal viability, or to deny such payments on behalf of any such indigent pregnant women for such abortions; and

(b) directing notice to any recognized and legal medical providers, or to persons receiving assistance under the Illinois medical assistance programs, that any medically necessary abortions performed prior to fetal viability, are not, or will not be, a covered service under the Illinois medical assistance programs.

7. Within 21 days from the entry of this Decree, or within such additional time as this Court may allow, defendant Quern is ORDERED TO—

(a) direct, by first-class mail, to all recognized and legal medical providers notices, certification forms, and revisions to the Handbook for Physicians, which explain, completely, the terms of ¶ 6(a) herein, and of the means by which such providers can secure reimbursement for medically necessary abortion services. (Defendant is further ORDERED to furnish such notices, forms and revisions to plaintiffs' attorneys at least seven working days prior to their official promulgation.);

(b) direct, by first-class mail, the notice attached hereto as Exhibit C (printed in English and Spanish) to all Illinois medical assistance program recipients who may be affected by this Decree.

8. (a) The question of defendants' liability for attorneys' fees, and the amount of such fees to plaintiffs, is reserved until further order of this Court. Plaintiffs need not submit

any claim for attorneys' fees until such time as this Court considers this question.

(b) Costs are awarded to plaintiffs.

ENTER:

JOHN F. GRADY,
United States District Judge.

DATED: April 30, 1979

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
NOTICE

TO: Physicians, Hospitals and Ambulatory Surgical Centers.

FROM: Illinois Department of Public Aid

RE: REIMBURSEMENT FOR ABORTIONS

Effective May 1, 1979, the Department of Public Aid, under Illinois law, as limited by the federal court, cannot pay for abortions except for three (3) specific reasons which are coded and described below. Payment can only be made after receipt of the new document "Application For Payment For Abortion", Form DPA 2217, which must be submitted with the billing code.

When billing on Form DPA 132, Physician's Statement of Services Rendered, for induced abortions that are reimburseable by the Department, please use the appropriate procedure code. The codes are as follows:

Code 59730 *Mother's Life Endangered*
The professional judgment of the physician that the life of the mother would be endangered if the fetus were carried to term.

Code 59740 *Severe and Long Lasting Health Damage*
The professional judgment of the physician that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term.

Code 59750 *Rape or Incest*

Illinois state law as limited by the federal court prohibits Medicaid payment for abortions for rape or incest unless the abortion would meet certain federal financial participation requirements, including the requirement that Illinois Department of Public Aid must receive signed documentation from a law enforcement agency or public health service stating:

a) The person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest;

b) The date on which the incident occurred;

c) The date on which the report was made which must have been within 60 days of the date on which the incident occurred;

d) The name and address of the victim and the name and address of the person making the report (if different from the victim); and

e) That the report include the signature of the person who reported the incident.

The Department of Health, Education and Welfare has stated that a provider who performs the procedure withing having the necessary documentation in hand does so at the risk of not receiving payment if the documentation is not forthcoming to the Illinois Department of Public Aid. The Illinois Department of Public Aid will pay for abortions required because of rape or incest only

when it has received the federally required documentation, or if the abortion was also necessary for the other federally reimburseable reasons as previously defined.

Hospitals, when billing the Department of Public Aid for abortions as defined in this release, are to attach a copy of the completed Application for Payment For Abortion, Form DPA 2217, to the hospital billing statement.

Attached is a copy of the Application For Payment For Abortion, Form DPA 2217. Form 1862 and any revised editions of Form 1862 will be obsolete and should not be used for services rendered after May 1, 1979.

Supplies of the Application For Payment For Abortion are maintained centrally and may be obtained by writing:

Provider Services Section
Post Office Box 4034
Springfield, Illinois 62708

If you wish, you may call (217) 782-1426.-

EXHIBIT "A"

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID

TO: RECIPIENTS OF AFDC, AABD, MANG, GA, AMI OR FOSTER CARE

RE: ABORTION SERVICES DATE: March 22, 1979

The Illinois Department of Public Aid will no longer pay for abortions performed on or after May 1, 1979, under any of the medical programs it administers, except where:

(a) a doctor has determined that the life of the mother would be endangered if the fetus were carried to term; or

(b) two doctors have determined that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term; or

(c) the abortion (or other medical procedure) is necessary for a victim of rape or incest, which such rape or incest has been reported promptly to a law enforcement agency or public health service.

NOTE: This report must be made within 60 days of the incident and must show the name and address of the victim and the date of the incident. It must show the name, address and signature of the person making the report and the date of the report.

Doctors and hospitals will not be able to accept medical identification cards for abortions except as specified above.

This action is being taken because state law (Ill. Rev. Stat. 5-5, 6-1 and 7-1), as limited by federal court rulings, prohibits IDPA from paying for any abortions other than those specified above.

YOU HAVE THE RIGHT TO APPEAL
THIS DECISION

At any time, within 60 days following the above "DATE" you have the right to appeal this decision and be given a fair hearing. Such an appeal must be in writing and filed with the Department. You may represent yourself at this hearing or you may be represented by any one else, such as a lawyer, relative or friend. Your local office will provide you with an appeal form and will help you fill it out if you wish.

EXHIBIT "B"

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID

TO: RECIPIENTS OF AFDC, AABD, MANG, GA or AMI, or FOSTER CARE

RE: ABORTION SERVICES DATE: May ——, 1979

ILLINOIS DEPARTMENT OF PUBLIC AID MUST PAY FOR MEDICALLY NECESSARY ABORTIONS

A Federal Court has ruled that the Illinois Department of Public Aid must pay for all abortions for pregnant women eligible for one of its medical assistance programs (Medicaid, General Assistance Medical, Aid to the Medically Indigent), if the abortion is "medically necessary" and performed prior to "fetal viability." An abortion is deemed to be "medically necessary" for a pregnant woman if the woman's doctor (in his/her professional judgment, exercised in light of all factors relevant to her well-being) deems is to be necessary for the preservation of her life or health. "Fetal viability" is usually placed at about seven months (28 weeks), but may occur earlier, even at 24 weeks.

If an eligible pregnant woman has an abortion after fetal viability, the Department of Public Aid will pay for such an abortion only where:

(a) a doctor has determined that the life of the mother would be endangered if the fetus were carried to term; or

(b) two doctors have determined that severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term.

In addition, the Department of Public Aid will pay for an abortion (or other medical procedure) when it is necessary for a victim of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service. (A pregnant woman under 18 is considered to have been the victim of rape, even if she was not forced to have sexual relations.) Note that under Illinois law, the required report must be made within 60 days of the incident and must show the name and address of the victim and the date of the incident. It must show the name, address and signature of the person making the report and the date of the report.

Because of the federal court ruling noted above, and previous federal court rulings, doctors, hospitals and clinics are now able to get paid for medical services for the types of abortions described above. Therefore, medical identification (green) cards can be presented for such abortion services, as for other types of medical services.

You may previously have been sent one or more other notices which said that the Department of Public Aid would *not* pay for most of the abortions described above. Please disregard such notices. They are no longer in effect.

Arthur F. Quern, Director
Illinois Department of Public Aid

EXHIBIT "C"

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DAVID ZBARAZ, M.D., etc., et al.,
Plaintiffs,
vs.
ARTHUR F. QUERN, etc., et al.,
Defendants.
No. 77 C 4522

AMENDED
NOTICE OF APPEAL

NOTICE IS HEREBY GIVEN that Defendant, ARTHUR F. QUERN, Director, Illinois Department of Public Aid, by and through his attorney, WILLIAM J. SCOTT, Attorney General, State of Illinois, hereby appeals to the Supreme Court of the United States pursuant to 28 U.S.C. § 1252 from the Memorandum Opinion dated April 29, 1979, and the Final Judgment and Order dated April 30, 1979, and docketed May 2, 1979, granting partial summary judgment for the plaintiffs, in the United States District Court for the Northern District of Illinois, Eastern Division, by the Honorable John F. Grady.

Defendant prays that the Final Judgment and Permanent Injunction be reversed.

The parties to this Order and the names and addresses of their respective attorneys are:

1. Plaintiffs-appellees who are represented by Robert W. Bennett, Esquire, 357 East Chicago Avenue, Chicago, Illinois 60611.
2. Plaintiffs-appellees, Zbaraz and Motew, who are represented by David Goldberger, Esquire, and Lois Lipton, Esquire, Roger Baldwin Foundation of ACLU, Inc., 5 South Wabash Avenue, Chicago, Illinois 60603.
3. Plaintiffs-appellees, Doe and Chicago Welfare Rights Organization, who are represented by Aviva Futorian, Esquire, Robert E. Lehrer, Esquire, Wendy Meltzer, Esquire, and James D. Weill, Esquire, Legal Assistance Foundation of Chicago, 343 South Dearborn Street, Chicago, Illinois 60604.
4. Defendant-appellant, Arthur F. Quern, Director of the Illinois Department of Public Aid, who is represented by William J. Scott, Attorney General, State of Illinois, William A. Wenzel, Special Assistant Attorney General (Of Counsel), 130 North Franklin, Suite 300, Chicago, Illinois 60606.
5. Defendants-appellants intervenors, Jasper F. Williams, M.D., and Eugene F. Diamond, M.D., who are represented by Patrick A. Trueman and John D. Gorby, Americans United for Life Legal Defense Fund, 230 North Michigan, Suite 515, Chicago, Illinois 60601.
6. Defendant-appellant intervenor, United States of America, which is represented by Jonathon Ginsburg, United States Department of Justice, Civil Division, 10th and Pennsylvania, N.W., Washington, D.C. 20530 and James Hynes, Assistant United States Attorney, 219 South Dearborn Street, Chicago, Illinois 60604.

Respectfully submitted,

WILLIAM J. SCOTT,
Attorney General,
State of Illinois.

WILLIAM A. WENZEL,
Special Assistant Attorney
General (Of Counsel),
130 North Franklin, Suite 300,
Chicago, Illiois 60606 (793-2380).

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DAVID ZBARAZ, M.D., etc., et al.,
Plaintiffs,
vs.
ARTHUR F. QUERN, etc., et al.,
Defendants.
No. 77 C 4522

NOTICE OF FILING

TO: See attached list.

PLEASE TAKE NOTICE that on the 8th day of May, 1979, the attached AMENDED NOTICE OF APPEAL was filed with the Clerk of the United States District Court for the Northern District of Illinois, Eastern Division, at the United States Courthouse, 219 South Dearborn Street, Chicago, Illinois.

WILLIAM J. SCOTT,
Attorney General,
State of Illinois.

WILLIAM A. WENZEL,
Special Assistant Attorney
General (Of Counsel),
130 North Franklin, Suite 300,
Chicago, Illiois 60606 (793-2380).

CERTIFICATE OF SERVICE

The undersigned being first duly sworn upon oath deposes and says that a copy of the foregoing was served upon the above named at the above address by depositing same in the United States mail chute at 160 North LaSalle, Chicago, Illinois on May 8, 1979.

..... BRYNES.

SUBSCRIBED and SWORN to
before me this 8th day
of May, 1979.

.....
NOTARY PUBLIC

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

JEFFREY C. MILLER, Acting Director, Illinois Department of Public Aid,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation, and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

BRIEF OF APPELLANT MILLER

WILLIAM J. SCOTT,
Attorney General of Illinois
Attorney for Appellant.

WILLIAM A. WENZEL, III,
JAMES C. O'CONNELL,
ELLEN P. BREWIN,
Special Assistant Attorneys General
130 North Franklin Street, Suite 300
Chicago, Illinois 60606
(312) 793-2380
Of Counsel

Printed by the Authority of the State of Illinois—1-80-97

INDEX

TABLE OF AUTHORITIES

Cases

Constitution, Statutes and Regulations

Miscellaneous Authorities

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

JEFFREY C. MILLER, Acting Director, Illinois Department of Public Aid,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation, and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

BRIEF OF APPELLANT MILLER

OPINIONS BELOW

The opinion of the District Court on review is reported at 469 F.Supp. 1212 (N.D. Ill. 1979) and is reproduced in the State's Jurisdictional Statement, A21. The prior District Court opinions are unreported. The abstention order of December 21, 1977 is in the Jurisdictional Statement of the United States. 91a; the memorandum opinion may be found at R. 13. The opinion of the United States Court of Appeals for the Seventh

Circuit reviewing the abstention order is reported at 572 F.2d 582 (7th Cir. 1978). The opinion of the District Court on remand is in the Jurisdictional Statement of the United States, 54a. The opinion of the Seventh Circuit on the statutory issues is reported at 596 F.2d 196 (7th Cir. 1979).

JURISDICTION

The Final Judgment and Order of the District Court (Jurisdictional Statement, A43) was entered on April 30, 1979. The State filed an amended Notice of Appeal to this Court on May 8, 1979 (App. 151). The Jurisdictional Statement was filed on July 2, 1979. The jurisdiction of this Court is invoked under 28 U.S.C. § 1252. *International Ladies' Garment Workers' Union* v. *Donnelly Garment Co.*, 304 U.S. 243 (1938); *United States* v. *Raines*, 362 U.S. 17 (1960); and *McLucas* v. *DeChamplain*, 421 U.S. 21 (1975).

QUESTIONS PRESENTED

1. Has the appellate jurisdiction of the Supreme Court under Title 28 U.S.C. § 1252 been properly invoked in this case?

2. Are the provisions of P.A. 80-1091 amending the Illinois Public Aid Code so as to limit public funding of abortions solely to those instances where an abortion is "necessary for the preservation of . . . life" consistent with the rights and obligations of the state under Title XIX of the Social Security Act as amended by the "Hyde Amendment" to the Departments of Labor, and Health, Education and Welfare Appropriation Act?

3. Without regard to the "Hyde Amendment," is Illinois free under Title XIX and its implementing regulations to exclude from the scope of coverage of its non-comprehensive state plan for medical assistance all abortions not "necessary for the preservation of . . . life"?

4. Does the Equal Protection Clause of the Fourteenth Amendment forbid the State of Illinois, through its normal democratic processes, from making a value judgment favoring its interests in fetal life and normal child birth over abortion, and implementing that judgment by the allocation of public funds to indigent, pregnant women seeking abortions only where "necessary for the preservation of . . . life"?

5. Does P.A. 80-1091 violate the Fourteenth Amendment rights of indigent, pregnant women seeking "medically necessary" abortions where the State funds alternative modes of treatment for the complications of pregnancy?

CONSTITUTIONAL AND STATUTORY PROVISIONS

Fifth Amendment, United States Constitution:

No person shall be . . . deprived of life, liberty, or property, without due process of law . . . .

Fourteenth Amendment, United States Constitution:

SEC. 1. . . . No state shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

P.A. 80-1091, ILL. REV. STAT. *ch. 23, §§ 5-5, 6-1, 7-1 (Supp. 1977)*

[This statutory provision is reproduced in full in the Addendum hereto, Add. 1a].

Departments of Labor, and Health, Education and Welfare, Appropriation Acts, for the fiscal years 1977, 1978, 1979 and 1980 (commonly known as the "Hyde Amendments")

[These statutory provisions are reproduced in full in the Addendum hereto, Add. 4a].

STATEMENT OF THE CASE

Jeffrey C. Miller, Acting Director of the Illinois Department of Public Aid and principal defendant in this action, is responsible for the administration of the Illinois Public Aid Code, ILL. REV. STAT. ch. 23, § 1-1 *et seq.* (1977).[1] The Illinois Department of Public Aid is the "single state agency" designated to administer the Illinois state plan for medical assistance under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*[2]

In 1977 the Illinois General Assembly, overriding the veto of Governor James R. Thompson, enacted into law P.A. 80-1091, which amended the scope of the state's medical assistance programs for the indigent by excluding as a covered medical procedure, and prohibiting public funding of, abortions for indigent pregnant women unless in the opinion of a treating physician an abortion is "necessary for the preservation of the life of the woman seeking such treatment." ILL. REV. STAT. ch. 23, §§ 5-5, 6-1, 7-1 (Supp. 1977).

On December 6, 1977, David Zbaraz, M.D. and Martin Motew, M.D., members of the Department of Obstetrics and Gynecology at Michael Reese Hospital in Chicago, Illinois, filed this class action under the Civil Rights Act, 42 U.S.C. § 1983, in the District Court for the Northern District of Illinois, Eastern Division, challenging the validity of P.A. 80-1091 on federal statutory and constitutional grounds. Alleging jurisdiction under 28 U.S.C. § 1331 and 28 U.S.C. § 1343(3), (4), the plaintiffs claimed that the state abortion funding limitation "denies them and their [pregnant] indigent women patients needing medically necessary abortions their rights under the Social Security Act, and the Ninth and Fourteenth Amendments to the United States Constitution." (R.1, Complaint, § 1). Plaintiffs sought declaratory and injunctive relief against defendant's threatened enforcement of P.A. 80-1091 and class certification under FED. R. CIV. P. 23 of a class of all physicians participating in the state's medical assistance programs and who perform "medically necessary" abortions for their indigent women patients (R. 18).

[1] At the time this case was filed, Arthur F. Quern was the Director of the Illinois Department of Public Aid and the principal defendant. In September of 1979, Director Quern resigned from office and was replaced by Jeffrey C. Miller, the current Acting Director.

[2] In addition to the state's Title XIX program, Director Miller also administers two wholly state authorized and funded public assistance programs—the General Assistance Program, ILL. REV. STAT. ch. 23, § 6-1 *et seq.* (1977); and the Aid to the Medically Indigent program, ILL. REV. STAT. ch. 23, § 7-1 *et seq.* (1977).

Jasper F. Williams, M.D. and Eugene F. Diamond, M.D. petitioned the District Court pursuant to FED. R. CIV. P. 24(a)(2) to intervene in the lawsuit as party-defendants in order to protect their own economic interests and for the purpose of representing the interests of unborn children which would be impaired were plaintiffs to prevail (R. 24). The motion for intervention was opposed by the plaintiffs and was taken under advisement by the court.

Because the District Court believed that the "life-preservation" standard utilized in P.A. 80-1091 could be interpreted by Illinois courts in a way that would avoid the federal statutory and constitutional challenges, an abstention order was entered by the District Court on December 21, 1977 in order to give the Illinois courts an opportunity to definitively construe the new legislation in the face of a claim that the statute excluded funding for "medically necessary" abortions as defined by the plaintiffs (R. 13).

Plaintiffs appealed the abstention order to the United States Court of Appeals for the Seventh Circuit. Pending the outcome of the appeal, the Seventh Circuit issued an injunction against enforcement of the Illinois statute and compelled the State to fund all "therapeutic" abortions. Relying on this Court's language in *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973),

the Court of Appeals defined "therapeutic" to mean "medically necessary or medically indicated according to the professional medical judgment of a licensed physician in Illinois, exercised in light of all factors affecting a woman's health." In *Zbaraz* v. *Quern*, 572 F.2d 582 (7th Cir. 1978) ("Zbaraz I") the Seventh Circuit reversed the District Court's abstention order but intimated no view on the merits of the relief plaintiffs were seeking. The Court dissolved its injunction and remanded the case for expeditious consideration of preliminary injunctive relief.

On remand, plaintiffs filed a motion for leave to have Jane Doe joined as a party-plaintiff and for leave to file amended and supplemental pleadings (R. 58, 59). The supplemental pleadings describe Plaintiff Doe as a 38 year old pregnant woman who was examined at Michael Reese Hospital by two physicians, not parties of record, on the staff of the hospital. In support of the supplemental pleadings, Plaintiff Zbaraz filed an affidavit (App. 92) which states that

> 1. . . . I have reviewed the medical records of Jane Doe, a patient at Michael Reese who was recently examined by two other physicians on the staff of the hospital. The records disclose the following:
>
> Jane Doe is 38 years old and has had nine previous pregnancies. She has a history of varicose veins and thrombophlebitis (blood clots) of the left leg. The varicose veins can be, and in her case were, caused by multiple pregnancies: the weight of the uterus on her pelvic veins increased the blood pressure in the veins of her lower extremities; those veins dilated and her circulation was impaired, resulting in thrombophlebitis of her left leg. The varicosities of her lower extremities became so severe that they required partial surgical removal in 1973.
>
> 2. Given this medical history, Jane Doe's varicose veins are almost certain to recur if she continues her pregnancy. Such a recurrence would require a second operative procedure for their removal. Given her medical history, there is also about a 30% risk that her

> thrombophlebitis will recur during the pregnancy in the form of "deep vein" thrombophlebitis (the surface veins of her left leg having previously been partially removed). This condition would impair her circulation and might require prolonged hospitalization with bed rest.
>
> 3. Considering Jane Doe's medical history of varicose veins and thrombophlebitis, particularly against the background of her age and multiple pregnancies, it is my view that an abortion is medically necessary for her, though not necessary to preserve her life.

The District Court by Order of April 25, 1978 granted plaintiffs leave to join Jane Doe as a party plaintiff and permitted the filing of amended pleadings (R. 62). Thereafter the parties, including the movants for intervention as party-defendants, filed cross motions for summary judgment (R. 56, 57, 63).

On May 15, 1978 the District Court issued a memorandum opinion which (1) granted the motion to intervene of Jasper F. Williams, M.D. and Eugene F. Diamond, M.D.; (2) certified two plaintiff classes pursuant to FED. R. CIV. P. 23(b)(2)[3]; (3) denied Defendant Quern's motion to dismiss for want of jurisdiction; and (4) granted plaintiffs' motion for summary judgment based solely on the statutory issues raised in the complaint (R. 64).

The court found that Section 101 of Pub. L. 95-205 (the Hyde Amendment to the Departments of Labor and Health, Education and Welfare Appropriations Act for 1978) was not intended by Congress to alter the substantive requirements of Title XIX with respect to state funding of "medically necessary"

---

[3] The classes certified by the District Court consist of (1) all pregnant women eligible for the Illinois Medical assistance programs for whom an abortion is medically necessary but not necessary for the preservation of their lives and who wish such abortion performed, and (2) all Illinois physicians who are certified to obtain reimbursement for necessary medical services rendered to and who perform medically necessary abortions for, persons eligible for medical services under [the "Illinois medical assistance programs"].

abortions.[4] Construing Title XIX to oblige participating states to fund all "medically necessary" services, the District Court concluded that P.A. 80-1091, by denying funds for abortions deemed "medically necessary" in the discretion of attending physicians, was inconsistent with the objectives of the Act, 42 U.S.C. § 1396, the "reasonable standards" requirement of § 1396a(a)(17) and implementing regulations governing the "amount, duration, and scope" of services, 42 C.F.R. § 449.10(a)(5)(i). [later recodified as 42 C.F.R. § 440.230 (c)(1) at 43 Fed. Reg. 57253 (Dec. 7, 1978)].

Upon appeal to the United States Court of Appeals for the Seventh Circuit, that Court again reversed, *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979) (*Zbaraz II*). The Court in *Zbaraz II*, agreeing with the First Circuit's decision in *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979) *cert. denied*, ____ U.S. ____, 99 S.Ct. 2181, 2182 (1979), held that the Hyde Amendment to the Medicaid Act was intended by Congress to

[4] Congress first enacted an abortion funding limitation under the sponsorship of Congressman Henry Hyde (Rep. Ill.) by adding a rider to the Departments of Labor, and Health, Education and Welfare Appropriation Act for 1977, [commonly referred to as the "Hyde Amendment."] which provided that, "None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term." Pub. L. 94-439, Section 209, 90 Stat. 1418, 1434 (Sept. 30, 1976). Congress passed a similar restriction the following year: "[N]one of the funds provided for in this paragraph shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term where so certified by two physicians." Departments of Labor, and Health, Education and Welfare and Related Agencies, Appropriation Act, 1978, Pub. L. 95-205, Section 101, 91 Stat. 1460 (Dec. 9, 1977). It was the 1978 Appropriation Act amendment which the District Court considered in its decision of May 15, 1978.

amend Title XIX in regard to abortions, and that under the Medicaid Act, as amended, Illinois could limit medicaid funding to the categories of abortions specified in that amendment.[5] Consequently, Illinois was free to deny funding for all "medically necessary" abortions which a physician could not certify as falling under one of the designated Hyde Amendment categories.

The ruling in *Zbaraz II* worked a judicial revision of P.A. 80-1091, by expanding its terms beyond its original "life-preservation" standard to encompass victims of rape and incest and instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term.

By interpreting the Hyde Amendment as a substantive modification of Title XIX and by revising P.A. 80-1091 to conform to the contours of the federal Act, the Court of Appeals concluded that the constitutional considerations, having been altered by its ruling, should now be passed on by the District Court and thus remanded the case with instructions to the court below to consider "whether the Hyde Amendment, by limiting funding for abortions to certain circumstances even if such abortions are medically necessary, violates the Fifth Amendment in view of the facts that no other category of medically necessary care is subject to such constraints and that abortion has been recognized as a fundamental right." 596 F.2d at 202. The Court of Appeals viewed the Fifth Amendment and Fourteenth Amendment issues as substantially identical with both the federal and state statutes rising or falling together as a result of the resolution of the constitutional issues. 596 F.2d at 203 n. 22.

[5] The Court of Appeals noted that Congress had enacted varying forms of the Hyde Amendment for fiscal years 1977, 1978, and 1979. 596 F.2d 196, 199. The 1979 version, Pub. L. 95-480, Section 210, 92 Stat. 1567, 1586 (Oct. 18 1978) was identical to that for 1978 and the Court of Appeals considered the legislative history of these later amendments in resolving the statutory question before it.

On remand, the District Court modified its permanent injunction so as to require the defendant to fund all Hyde Amendment abortions in his enforcement of P.A. 80-1091 (R. 87).

Since the constitutionality of a federal statute had been drawn into question, Judge Kirkland certified this fact to the Attorney General of the United States pursuant to 28 U.S.C. § 2403(a) and directed the Attorney General to notify the court whether the United States intended to seek permission to intervene for presentation of evidence and for argument on the question of the Hyde Amendment's constitutionality (R. 90).

The United States by letter to Judge Kirkland (App. 100) requested leave to formally intervene pursuant to 28 U.S.C. § 2403(a) and the court granted this request by order of March 8, 1979 (R. 94). Thereafter each party submitted to the Court a motion for summary judgment supported by briefs addressing the constitutional issues (R. 98, 106, 107). Due to health reasons, Judge Kirkland recused himself prior to ruling and the case was reassigned to Judge Grady (R. 115).

In a memorandum opinion dated April 29, 1979 Judge Grady held that the Hyde Amendment and P.A. 80-1091 (as modified by court order) were constitutionally infirm as violative of the plaintiffs' right to equal protection of the laws. *Zbaraz* v. *Quern*, 469 F. Supp. 1212 (N.D. Ill. 1979).

Based upon its reading of the affidavits of Drs. Zbaraz, Depp, and Barglow filed in support of Plaintiffs' Motion for Summary Judgment (App. 102, 113, 123), the District Court concluded that the effect of the Hyde Amendment criteria "will be to increase substantially maternal morbidity and mortality among indigent pregnant women." 469 F. Supp. at 1220. Judge Grady therefore held that "the state has [no] legitimate interest in preserving the life of a non-viable fetus at the cost of increased maternal morbidity and mortality among indigent pregnant women." *Id.*

In the Final Judgment order of April 30, 1979 (R. 124), the federal and state abortion funding statutes, as applied prior to fetal viability, were declared to violate plaintiffs' rights to equal protection of the laws as guaranteed by the Fifth and Fourteenth Amendments, respectively. The order enjoined the state defendant from enforcing P.A. 80-1091 as judicially amended, prior to fetal viability, and compelled the funding of all "medically necessary" abortions under the Illinois medical assistance programs.[6]

Motions by Defendant Quern and the intervening defendants for a stay of the final order pending appeal (R. 123, 125) were denied, without reason, by orders of the court (R. 124, 126). Defendant Quern, upon denial of his stay motion, sought an order requiring the United States to reimburse Illinois for all Title XIX "medically necessary" abortions which would be performed under the Final Judgment Order but which did not meet the Hyde Amendment criteria (App. 143). The United States advised the court that, while the reimbursement issue was not ripe since no federal funds had yet been denied the state, it had no intention of reimbursing Illinois for any non-Hyde Amendment abortions which would be performed as a result of Judge Grady's ruling.[7] The state's motion was entered and taken under advisement (R. 124), and it is presently pending before the District Court.

On May 2, 1979 Defendant Quern filed a Notice of Appeal which indicated that he was appealing the order of April 30th directly to the Supreme Court (R. 127). Intervenors Williams

---

[6] The Court defined a "medically necessary" abortion as one "necessary for the preservation of the life or the physical or mental health of a women seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in light of all factors relevant to her health." *See*, Appendix to the State's Jurisdictional Statement, A 44.

[7] The Final Judgment order grants injunctive relief only against the state defendant with respect to enforcement of P.A. 80-1091.

and Diamond filed a similar Notice of Appeal on the same day (App. 146). Because his original Notice of Appeal failed to specify that the appeal was pursuant to 28 U.S.C. § 1252, Defendant Quern filed an Amended Notice of Appeal with the required specification on May 8, 1979 (R. 130). On May 29, 1979 the United States filed its § 1252 Notice of Appeal from the April 30th Judgment invalidating the Pub. L. 95-480, § 210, 92 Stat. 1586 (1978) (App. 154).

Director Quern and intervenors Williams and Diamond then applied to Mr. Justice Stevens, Circuit Justice for the Seventh Circuit, for a stay of the judgment order pending appeal. In a written opinion, Mr. Justice Stevens denied the applications for a stay despite a recommendation by the Solicitor General on behalf of the United States that the applications be granted. *Williams* v. *Zbaraz*, ____U.S.____, 99 S.Ct. 2095 (1979). Thereafter, the intervenors presented their application for a stay to Mr. Justice Rehnquist who, in turn, submitted it to the entire Court which denied the application without opinion. ____U.S. ____, 99 S.Ct. 2833 (1979).

The Jurisdictional Statements of Defendant Miller and the intervening defendants were filed in the Supreme Court on July 2, 1979, and that of the United States, with leave of court, on September 21, 1979. Plaintiffs, in response, filed a Motion to Vacate in Part, to Dismiss in Part, and to Affirm. They also filed a Conditional Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit. Both documents assert a common rationale for the Court's disposition of the case. The Hyde Amendment, plaintiffs assert, is not now and never has been an issue in this case and thus the Seventh Circuit committed reversible error in finding that Congress intended that Act to substantively modify a state's obligations under Title XIX. Since the mandate of the Court of Appeals, directing the District Court to resolve the constitutionality of the Hyde Amendment was without basis, plaintiffs contend that this Court has no Article III jurisdiction to review Judge Grady's

ruling as to the Hyde Amendment. Plaintiffs urge this Court to vacate that portion of the final order granting relief with respect to the Hyde Amendment and otherwise affirm the ruling below. Plaintiffs contend that 28 U.S.C. § 1252 provides no basis for review of any of the prior rulings of the courts below. If, however, the entire case does come before the Court, plaintiffs urge affirmance of *Zbaraz II*, insofar as it interprets Title XIX, standing alone, to require funding for "medically necessary" abortions, and reversal, to the extent that the Court of Appeals held that the Hyde Amendment operates substantively to amend Title XIX to permit Illinois to deny funding for most "medically necessary" abortions.

On November 26, 1979 the Court granted review of the issues presented in the several Jurisdicitional Statements, postponed consideration of the question of the Court's jurisdiction under Section 1252 until the hearing on the merits, and consolidated the three appeals. No action has been taken to date with respect to plaintiffs' Petition.

Congress, in making appropriations for the Departments of Labor, and Health, Education and Welfare and related agencies for the fiscal year ending September 30, 1980 resolved for the fourth consecutive year to limit the funding of certain categories of abortions. House Joint Resolution 440, signed into law as Pub. L. 96-123, 93 Stat. 923, 926 (Nov. 20, 1979) provides:

> SEC. 109. Notwithstanding any other provision of this joint resolution except section 102, none of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service.

SUMMARY OF THE ARGUMENT

28 U.S.C. § 1252 authorizes an appeal directly to the Supreme Court from the ruling below declaring Pub. L. 95-480, Section 210, 92 Stat. 1586 (commonly known as the "Hyde Amendment" to Title XIX of the Social Security Act) and its Illinois counterpart, P.A. 80-1091, violative of the United States Constitution. While plaintiffs did not directly challenge the validity of the Hyde Amendment, they did assert a right to relief under Title XIX, 42 U.S.C. § 1396 *et seq.* which required the federal court to interpret the intent of Congress in enacting the Hyde Amendment and to relate that intent to the authority of a state to alter its Medicaid state plan to exclude funding of those abortions which, under the Hyde Amendment, no longer qualified for federal reimbursement.

Since the Medicaid program's essential feature is the shared funding concept, plaintiffs' assertion of a statutory entitlement to "medically necessary" abortions, if true, would have the anomalous result of shifting to the states the costs of funding all such abortions, thereby irreparably altering the basic nature of the compact between Illinois and the Federal government in a scheme of co-operative federalism. Thus the issue of the validity of P.A. 80-1091 under Title XIX was inextricably interrelated to the intent of Congress in enacting the Hyde Amendment and the validity of the federal law.

Since the United States intervened in the case as a party-defendant to defend the validity of the Hyde Amendment and the Court ruled the federal act to be constitutionally infirm, the conditions precedent for a direct appeal under 28 U.S.C. § 1252 have been satisfied. *McLucas* v. *DeChamplain*, 421 U.S. 21 (1975).

Under a Section 1252 appeal, the Court may review all prior rulings below, including statutory rulings of the Court of Appeals. *Fusari* v. *Steinberg*, 419 U.S. 379 (1975). A review of the prior statutory rulings is appropriate since they may be

dispositive of the case thereby avoiding unnecessary constitutional adjudication. In addition, an initial analysis of the statutory questions is desirable as this may alter the constitutional considerations, *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979), or narrow the formulation of a rule of Constitutional law. *United States* v. *Raines*, 362 U.S. 17 (1960).

Illinois has observed a long-standing policy of protecting the life of unborn children and of limiting abortion except where necessary for the preservation of the mother's life. The legislative history surrounding the enactment of P.A. 80-1091 which limits state funding of abortions except where necessary for the preservation of the life of an indigent pregnant woman reflects the legislature's concern that fetal life be protected without endangering maternal health. Abortion was seen as a unique medical procedure, seldom medically necessary to preserve maternal life, and ethically objectionable to the taxpayers of the state who do not want their tax dollars subsidizing the termination of unborn children. The people of the State of Illinois are willing to spend more money to encourage normal childbirth than to pay for all "medically necessary" abortions which concedely would cost less.

The concept of "medically necessary" abortions which plaintiffs seek to vindicate is tantamount to abortion on demand. It fails to consider a physician's obligation to *both* of his patients, the mother and the unborn child. It is devoid of the bioethical considerations which the medical profession recognizes are present in any situation involving pregnancy and abortion. It ignores the fact that most complications of pregnancy are readily treatable by alternative forms of treatment without recourse to abortion. The Illinois "life-preservation" standard does not impose upon medicaid physicians a requirement of "predictive certainty" foreign to the medical profession, which would cause "increased maternal morbidity and mortality." If there is a reasonable probability

that the co-existence of pregnancy and diseases complicating pregnancy will materially and significantly shorten the mother's life or that the pregnancy raises the risk of death, a physician may reasonably conclude that the "life-preservation" standard of the statute may be invoked. Illinois does not hold its Medicaid physicians to a standard of care or diagnosis which differs from the standard that the law otherwise holds them to when it subjects their professional activities to judicial scrutiny, namely, the rendering of medical judgments based upon a reasonable medical probability or certainty.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (the "Medicaid program") is a scheme of co-operative federalism wherein participating states have wide latitude to determine the amount, duration and scope of medical assistance which eligible individuals are entitled to receive. 42 U.S.C. § 1396a(a)(17). The act does not contain a requirement that states fund all "medically necessary services." *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979). The act does not define the term "medical assistance" and nowhere mentions any particular medical procedure such as abortion. Illinois' state plan of medical assistance is a non-comprehensive plan and reserves to the state the determination of what is "necessary" care.

Neither the terms of Title XIX nor its implementing regulations require Illinois to fund all abortions deemed "medically necessary" by participating physicians. 42 C.F.R. § 440.230 permits Illinois to limit the "amount, duration and scope" of medical assistance in a non-arbitrary fashion. The state's limitation on the funding of "medically necessary" abortions is reasonable because of the uniqueness of the procedure of abortion which involves, unlike other medical procedures, the termination of fetal life. Since Illinois willingly funds alternative modes of treatment for the complications of pregnancy not encompassed within the "life-preservation" standard of P.A. 80-1091, the state's funding limitation is both reasonable and consistent with the objectives of Title XIX.

The Hyde Amendments to the annual appropriation measures for the Departments of Labor and Health, Education and Welfare for the years 1977, 1978, 1979, and 1980 have altered the obligations of states participating under Title XIX with respect to abortion funding. *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979); *Zbaraz* v. *Quern*, 596 F.2d 196 (7th Cir. 1979). While the Courts of Appeals found that the Hyde Amendment worked a substantive modification to a *mandatory* obligation of the states under Title XIX, the better view is that the federal statute altered the states' *discretionary authority* to fund or not fund "medically necessary" abortions. The legislative history of the federal statute provides support for this view.

It may not be fairly argued that the Hyde Amendment did *not* substantively modify prior law. The judicial standard for finding a substantive modification of prior law is readily satisfied. *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153 (1978). The alternative interpretation of the Hyde Amendment as simply an appropriation measure affecting only federal funding of certain categories of abortions is without any support in the debates of Congress. Moreover, to accept this interpretation would lead to the conclusion that the states would have to assume the full financial responsibility for the funding of abortions as part of a scheme of co-operative federalism. This result would alter the basic scheme of the federal-state sharing of expenses and be tantamount to a repeal by implication of the funding provisions of Title XIX. There is no evidence that this is what Congress intended by enacting the Hyde Amendment.

Illinois' abortion funding limitation is consistent with the Fourteenth Amendment's guarantee of due process and equal protection of the laws. There is no fundamental right to an abortion or to a state funded abortion. *Maher* v. *Roe*, 432 U.S. 464 (1977). Welfare is not a fundamental right. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975).

Traditional equal protection analysis requires a determination of the nature of the right involved and whether the statutory classification operates to the disadvantage of some suspect class or impinges upon some fundamental right protected by the Constitution. *San Antonio School District* v. *Rodriquez*, 411 U.S. 1 (1973)

The right to a publicly funded "medically necessary" abortion is not fundamental and is distinct from the right to privacy recognized in *Roe* v. *Wade*, 410 U.S. 113 (1973). As long as a statutory classification does not unduly interfere with a woman's privacy right, that right does not limit the authority of the state to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds. *Maher* v. *Roe*, 432 U.S. 464 (1977) The Illinois statute places no obstacles in the pregnant woman's path to a "medically necessary" abortion not necessary to preserve her life. The obstacle is the woman's indigency. The effect of the law is not unduly burdensome on the woman since the state is willing to provide her with alternative forms of medical treatment to protect the woman's interest in her health. The "life-preservation" standard at issue here is essentially the same as the standard upheld by the Court in *Poelker* v. *Doe*, 432 U.S. 519 (1977).

Neither the pregnant woman nor her physician may successfully assert a substantive due process claim based upon the right to privacy found in *Roe* v. *Wade* as a basis for invalidating P.A. 80-1091. In the area of social welfare and economic legislation, the Court has consistently refused to sit as a "super-legislature" to weigh the wisdom of legislation. The statutory funding limitation presents none of the indicia for due process scrutiny for it neither intrudes upon, coerces or criminalizes the exercise of the privacy right. Moreover, when a woman and her physician assert a right to public funds for an abortion, the issue is no longer one of privacy and the

constitutional focus switches to the public domain and to prerogatives of the legislature to set policy for the community as a whole.

P.A. 80-1091 does not create a suspect classification based on wealth and does not fall into any of the traditional indicia of suspect classes. Illinois' policy to refuse to fund all "medically necessary" abortions does not amount to the imposition of a penalty upon poor women who choose to exercise their *Roe* v. *Wade* right to decide to terminate their pregnancy. Illinois does not deny medical assistance benefits to women seeking a "medically necessary" abortion since it willingly funds alternative forms of treatment for the complications of pregnancy. There is no valid reason to believe that enforcement of the "life-preservation" standard will necessarily result in "increased maternal morbidity and mortality" given the availability of alternative modes of treatment and the reasonable interpretation which the state places upon the "life-preservation" standard.

This case does not present a need for the Court to subject the state law to heightened judicial scrutiny or to demand that the state have a compelling interest justifying the statutory classification. P.A. 80-1091 satisfies the traditional standard of equal protection scrutiny, *Dandridge* v. *Williams*, 397 U.S. 471 (1970), by rationally furthering important and legitimate state interests in fetal life, encouragement of childbirth, population growth and demographic concerns, and fiscal autonomy in the allocation of state funds in a manner reflecting the ethical concerns of its citizens for the principle of the sanctity of human life. *Maher* v. *Roe* and *Poelker* v. *Doe* are dispositive of plaintiffs' constitutional challenge to the validity of P.A. 80-1091. The District Court erred in finding that the state's interest in fetal life was outweighted by the interest in maternal health since the statute adequately protects both interests without lessening the principle of the sanctity of human life. The decision of the District Court should be reversed.

ARGUMENT

I.

28 U.S.C. § 1252 CONFERS APPELLATE JURISDICTION UPON THIS COURT TO REVIEW DIRECTLY THE RULING OF THE DISTRICT COURT

A.

28 U.S.C. § 1252 Authorizes An Appeal Directly To The Supreme Court Whenever A Federal Statute Is Declared Unconstitutional And The United States Is A Party.

By Order of November 26, 1979 this Court agreed to review the ruling of the Honorable John F. Grady, United States District Judge, for the Northern District of Illinois, declaring Pub. L. 95-480, Section 210, 92 Stat. 1586 (commonly referred to as the "Hyde Amendment" to Title XIX of the Social Security Act) and its Illinois counterpart, P.A. 80-1091 to be violative of the Fifth and Fourteenth Amendments to the United States Constitution, respectively. This Court postponed consideration of the question of jurisdiction to the hearing on the merits and it is that question which Director Miller initially addresses.

Title 28 U.S.C. § 1252 authorizes a direct appeal from any federal court decision holding an Act of Congress unconstitutional where the United States is a party to the action:

> Any party may appeal to the Supreme Court from an interlocutory or final judgment, decree or order of any court of the United States . . . holding an Act of Congress unconstitutional in any civil action, suit, or proceeding to which the United States or any of its agencies, or any officer or employee thereof, as such officer or employee is a party.

> A party who has received notice of appeal under this section shall take any subsequent appeal or cross appeal to the Supreme Court. All appeals or cross appeals taken to other courts prior to such notice shall be treated as taken directly to the Supreme Court.

Doubts regarding the Court's appellate jurisdiction apparently stem from the fact that on its face plaintiffs' Complaint seeks no relief with respect to the Hyde Amendment and only challenges the validity of P.A. 80-1091. This fact, however, fails to resolve the jurisdictional question against the defendant for it is plain from the claims that were specifically raised in plaintiffs' pleadings that a determination of the validity of the federal law was unavoidable. By asserting a right to relief under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (App. 9, ¶¶ 1, 9-15, 21, 24), plaintiffs tied the fate of their claims to an interpretation by the federal courts of the intent of Congress in legislating an abortion funding limitation in an appropriations measure authorizing funds for Title XIX services.

P.A. 80-1091 cannot be considered in a vacuum. Medicaid is a program of "co-operative federalism" between the states and the federal government.[8] Congress has statutorily defined the rules of the partnership and the United States Department of Health, Education and Welfare will not authorize federal funds for any Title XIX state plan which fails to conform to the mandatory provisions of the Act as interpreted in the implementing regulations promulgated by that agency. 42 U.S.C. § 1396c. The basic agreement of this federal-state partnership is the concept of shared funding of the costs of delivering medical services to the indigent by which each state which chooses to participate is guaranteed to receive federal reimbursement of, at a minimum, fifty percent (50%) of its total authorized expenditures for medical care for Title XIX recipients. *See*, 42 U.S.C. § 1396b(a)(1) and § 1396d(b).

---

[8] *See, King* v. *Smith*, 392 U.S. 309, 313, 316 (1968).

Absent this fundamental provision, there would neither be an incentive for state participation nor a scheme of "co-operative federalism."[9]

Since plaintiffs' statutory claim was that Title XIX mandated that Illinois as a condition of receiving federal funds pay for "medically necessary" services, including "medically necessary" abortions, the Seventh Circuit Court of Appeals correctly perceived that to sustain this claim it was necessary first to discern the intent of Congress in refusing to appropriate federal funds for the very medical procedure at issue in the case. Had the Court accepted plaintiffs' Supremacy Clause argument that P.A. 80-1091 was inconsistent with Title XIX (as interpreted without regard to the Hyde Amendment) the anomalous result would have been to shift the full financial responsibility for Title XIX abortion funding to the State of Illinois, thereby irreparably altering the basic nature of the compact between Illinois and the federal government under Title XIX.

While this factor is sufficient to justify the conclusion of the Seventh Circuit that a resolution of the issue of the validity of P.A. 80-1091 under Title XIX was inextricably interrelated with the significance of the Hyde Amendment, there is additional support for defendant's assertion that the jurisdiction of the Court has been properly invoked. The Court should note that the members of the Illinois General Assembly who debated the passage of P.A. 80-1091 were fully aware of, and motivated by, two events which were federal in origin: Congressional enactment of the Hyde Amendment and this Court's decisions in *Beal* v. *Doe*, 432 U.S. 438 (1977), *Maher* v. *Roe*, 432 U.S. 464

[9] That the shared funding provision defines the essential nature of the Medicaid program was noted by Judge Dooling in *McRae* v. *Mathews*, 421 F. Supp. 533, 538 (E.D.N.Y. 1976), *vacated mem., sub nom., Califano* v. *McRae*, 433 U.S. 916 (1977) where he rejected the argument that passage of the 1977 version of the Hyde Amendment left intact the obligation of the state of New York to fund abortions for which it would receive no federal reimbursement under Title XIX.

(1977), and *Poelker* v. *Doe*, 432 U.S. 519 (1977). See, Transcripts of Debate on House Bill 333 [P.A. 80-1091] at App. 42-52, 65-68, and 78-80. Since these decisions negated the notion that state-funded non-therapeutic abortions were a matter of statutory or constitutional entitlement, P.A. 80-1091 may be seen as Illinois's decision to restructure its Medicaid program to comport with Title XIX, as altered by the Hyde-Amendment, especially in view of the fact that Mr. Justice Powell's ruling in *Beal* referred to the federal abortion funding prohibition. *Beal* v. *Doe*, *supra*, 432 U.S. at 447, n.14.

Moreover, plaintiffs themselves raised the issue of Illinois' reliance on the Hyde Amendment before the defendant even had an opportunity to file any pleading in the case. *See*, Memorandum in Support of Motion for Temporary Restraining Order, (R. 17, p. 11). With the Hyde Amendment at issue by the very nature of plaintiffs' claim, the District Court could not avoid addressing the significance of the federal Act in passing on plaintiffs' Title XIX challenge. *See*, Memorandum Opinion and Order of May 15, 1978, (R. 64). Furthermore, when the Seventh Circuit ruled in *Zbaraz II* that Illinois' statute must be judicially expanded to match the dictates of the Hyde Amendment, the destiny of both statutes became irrevocably intertwined. Once the Court of Appeals found that the more restrictive portions of the Illinois statute were not in compliance with Title XIX, then both the Illinois statute *as construed* and the Hyde Amendment became identical. Thus, any resolution of the constitutional issues would pertain equally to either statute.[10] The Court of Appeals ordered the lower court to

[10] Plaintiffs may not fairly contend that an analysis of the federal statute under the Fifth Amendment and the state statute under the Fourteenth Amendment might be different. Although the Fifth Amendment does not include a specific Equal Protection Clause it has been held to incorporate equal protection rights under its Due Process Clause. *Weinberger* v. *Salfi*, 422 U.S. 749, 770 (1975). Therefore, the Court of Appeals was correct in its view that a review of both statutes would be essentially the same. *Zbaraz* v. *Quern*, *supra*, 596 F.2d at 203 n. 32.

consider the constitutional issues as they related to both statues because it correctly perceived the interrelated and inseparable nature of both statutes.

Finally, all the defendants formally took the position that they were entitled to summary judgment pursuant to FED. R. CIV. P. 56 based upon the constitutionality of the Hyde Amendment under the Fifth Amendment to the Constitution (R. 98, 106, 107). Moreover, after the District Court had declared both the federal and state statutes unconstitutional, Defendant Quern filed a motion to require federal reimbursement for all "medically necessary" abortions (App. 143). Thus, the issue of the constitutionality of the Hyde Amendment was expressly at issue in the case in at least three ways. First, it was addressed of necessity by the court below because of the essential relatedness of the state and federal limitations on abortion funding. Second, it arose by virtue of the pleadings filed by the defendants, even if not by the plaintiffs. Finally, the Seventh Circuit's construction of P.A. 80-1091 rendered the state law identical to the federal act.

The District Court, therefore, properly reached the issue of the constitutionality of the Hyde Amendment, and in reaching a decision holding it invalid provided the basis upon which the defendants have invoked the jurisdiction of this Court under Section 1252. Before the District Court even considered the constitutional issues, it certified to the Attorney General of the United States that the constitutionality of an Act of Congress had been drawn into question (R. 90). The United States requested permission to intervene and the District Court issued an order granting the request (R. 94). The District Court subsequently held the Hyde Amendment, an Act of Congress, unconstitutional. The District Court's conclusion that the Hyde Amendment was unconstitutional was the basis for its order directing that the state fund certain "medically necessary" abortions. Section 1252 is "properly invoked when the court below has made [a] determination of unconstitutionality [that] forms the necessary predicate to the grant or denial of

. . . relief." *McLucas* v. *DeChamplain*, 421 U.S. 21, 30 (1975); *United States* v. *Raines*, 362 U.S. 17, 20 (1960). Since the United States became a party to the case and the District Court held an Act of Congress unconstitutional, each of the requirements of Section 1252 have been met and this Court has jurisdiction to review the decision of the District Court.

B.

An Appeal Pursuant To 28 U.S.C. § 1252 Permits The Court To Review The Entire Case Including All Prior Rulings Below.

Plaintiffs have contended that unless the Court grants their Conditional Petition for Writ of Certiorari the statutory ruling of the Seventh Circuit is not susceptible to review by this Court within the confines of a proper Section 1252 appeal.[11] This assertion is erroneous and regardless of whether the Court ultimately reaches the merits of the constitutionality of federal and state abortion funding limitations, it is both appropriate and desirable that the Court first review the Supremacy Clause rulings below.

The authority to review prior statutory rulings in a Section 1252 case which ostensibly seeks review only of a constitutional ruling below is well established. This Court has long held that once jurisdiction is established under Section 1252, the *entire* case is brought before the Court, allowing the Court to consider all issues arising in the case, including non-constitutional ones. *Fusari* v. *Steinberg*, 419 U.S. 379, 387 n. 13 (1975); *United States* v. *Raines, supra*, 362 U.S. at 24 n. 4.

---

[11] *See*, Plaintiffs' Conditional Petition for Writ of Certiorari, p. 12-14, n. 13, n. 14; Motion To Vacate In Part, To Dismiss In Part, And To Affirm pp. 25-33.

In the *Fusari* case.[12] neither party appealed from the statutory portion of the lower court's decision. The court found that the statutory issues could be considered even though not specifically presented by any party because it had jurisdiction over the whole case.

The principle under which the Court is deemed to have all issues before it in a case in which an Act of Congress has been declared unconstitutional clearly has its origins in another firmly established rule of this Court—the avoidance of unnecessary constitutional adjudication. One of the most recent expositions of this principle was set forth in *New York City Transit Authority* v. *Beazer,* 440 U.S. 568, 582 (1979):[13]

> If there is one doctrine more deeply rooted than any other in the process of constitutional adjudication, it is that we ought not pass on questions of constitutionality . . . unless such adjudication is unavoidable. *Spector Motor Co.* v. *McLaughlin,* 322 U.S. 101, 105, 65 S.Ct. 152, 154, 89 L.Ed. 101.

Under the operation of the principle, a court is obligated to consider whether the statutory issues might be dispositive before reaching the constitutional question.

Were the Court to accept plaintiffs' argument that the jurisdiction of the Court on appeal does not extend to the entire case and all the rulings below, the Court would be forced in

[12] Although the *Fusari* case was brought under 28 U.S.C. § 1253, the Court stated that in regard to this issue the same principles govern cases brought under both Sections 1252 and 1253. *Fusari* v. *Steinberg, supra,* 419 U.S. at 387 n. 13.

[13] In both the *Beazer* case and *Califano* v. *Yamasaki,* ____ U.S. ____, 99 S.Ct. 2545, 2553 (1979), the courts below either declined to expressly rule on the statutory issues or failed to consider them at all. On review, the Court considered the statutory issues first, and specifically commented on the failure of the court below to do so, stating in the *Beazer* case that "We do not condone this departure from settled federal practice." 440 U.S. at 582.

effect to violate its long standing rule against unnecessary constitutional adjudication. The interrelation of the two principles in a case in which the constitutional issue provides the basis for a direct appeal is perhaps best illustrated in the *Fusari* case cited above.[14] Despite the failure of either party to raise the statutory issue, the Court felt "compelled to re-examine a statutory claim that may be dispositive before considering a difficult constitutional one." *Fusari* v. *Steinberg, supra,* 419 U.S. at 387 n. 13.

Moreover, an initial analysis of the statutory questions is desirable since this may "alter the constitutional considerations," *Zbaraz* v. *Quern,* 596 F.2d 196, 202, and aid the Court in formulating the issues in a manner which gives force to a related principle observed by the Court: "never to formulate a rule of Constitutional law broader than is required by the precise facts to which it is to be applied." *United States* v. *Raines, supra,* 362 U.S. at 21.

Plaintiffs claim, however, that the term "whole case" as used by this Court in direct appeal cases does not include the statutory issues which were before the Court of Appeals.[15] In support of their contention, they rely upon certain decisions of this Court such as *Farmers & Mechanics National Bank* v. *Wilkinson,* 266 U.S. 503 (1925) and *Union Trust Co.* v. *Westhus,* 228 U.S. 519 (1913). In the *Union Trust* case, the constitutional issue arose by way of an amendment to the

[14] Similarly, the parties in the case of *Regents of the University of California* v. *Bakke,* 438 U.S. 265, 281 (1978), which was before the Court on a Petition for Certiorari originally briefed and argued only the constitutional issues. This Court then requested supplementary briefing on the statutory questions and went on to consider the statutory issues in the case before reaching the constitutional ones.

[15] Yet plaintiffs have argued in their Motion to Vacate in Part, To Dismiss In Part, and To Affirm, page 29, that the Court's jurisdiction does extend to "matters which might provide alternative grounds for affirmance of that decision." The statutory issues fit precisely into that category.

pleadings in the lower court after the nonconstitutional issues had already been decided by the circuit court of appeals. The Court specifically stated:

> There can equally be no doubt that if we have power to pass upon the case on this record, our jurisdiction embraces not only the right to decide the alleged constitutional question raised after the mandate of the circuit court of appeals had been filed in the trial court, but also *all other questions arising on the record, including those passed upon by the circuit court of appeals.* 228 U.S. at 522 (emphasis added).

The Court could not have stated in more unequivocal terms that under the long established rule that the entire case comes before it in direct appeal cases involving the constitutionality of a federal statute, it could review the court of appeals decision.

The Court in the *Union Trust* case went on, however, to decide that it had no jurisdiction to review the case at all due to other limits on its jurisdiction to review decisions of courts of appeals. In reaching its decision, the Court considered the two competing principles—that of hearing the entire case and that of limiting its jurisdiction—and decided to follow a strict approach in determining its jurisdiction. At the time the case was decided, the mandatory jurisdiction of the Court in regard to cases brought under the statutory precursor to Section 1252 extended to an extremely broad class of cases.[16] In order to limit its docket and to avoid falling hopelessly behind in its

[16] The *Union Trust* and *Wilkinson* cases were brought to the Court under the Judicial Code of 1891 (Act of Mar. 3, 1891, ch. 517, § 5, 26 Stat. 827) and the Judicial Code of 1911 (Act of Mar. 3, 1911, Pub. L. 61-475, 36 Stat. 1087) respectively. Those statutes provided for direct appeals from the district court to the Supreme Court in several instances. For example, any case involving the construction or application of the Constitution of the United States, in which the constitutionality of any law of the United States was drawn into question or in which the constitution or law of a state was claimed to be in contravention of the Constitution of the United States could be appealed directly from the district court to the Supreme Court.

caseload, the Court traditionally adopted a very strict and narrow interpretation of the various jurisdictional statutes.[17]

While this Court has adhered to a restrictive interpretation of such obligatory jurisdictional statutes as 28 U.S.C. § 1253, *see, for example, Gonzales* v. *Automatic Employees Credit Union,* 419 U.S. 90 (1974), cases brought under Section 1252 have not been subjected to the same strict construction. *McLucas* v. *DeChamplain, supra,* 421 U.S. at 31 (1975). The explanation for this difference may be in the fact that subsequent to the ruling in the earlier cases relied on by plaintiffs the jurisdictional statutes permitting direct appeals were substantially altered in 1925 and again in 1937 when Congress reduced drastically the obligatory jurisdiction of the Court.[18] Section 1252, which by its terms limits the Court's direct appeal jurisdiction to instances wherein both an Act of Congress has been declared unconstitutional and the United States is a party to the action, itself acts to sharply curtail the number of cases on the Court's obligatory docket.[19] Thus, there is no pressing practical need for the Court to apply a strict construction to the statute. More importantly, however, in the *McLucas* case, the Court felt compelled to adopt an exception to the strict approach because "in § 1252 Congress unambiguously mandated an exception to this policy in the narrow circumstances that the section identifies . . ." 421 U.S. at 31. Mr. Justice Powell, speaking for the Court, clearly enunciated that the reasons for the exception were:

[17] The burden on the Court due to the excessive number of cases on its obligatory docket spurred a movement for reform, which was led by Chief Justice Taft. *Report of the Study Group on the Caseload of the Supreme Court* (Federal Judicial Center, 1972), 57 F.R.D. 573, 583.

[18] *See,* Act of Feb. 13, 1925, Pub. L. 64-451, 43 Stat. 938 and Act of Aug. 24, 1937, Pub. L. 75-352, §§ 2, 5, 50 Stat. 752, 753.

[19] It has been reported that "in recent years it has been very rare for district courts to strike down Acts of Congress and thus the direct appeal provision [under Section 1252] is used very little." *Report of the Study Group on the Caseload of the Supreme Court* (Federal Judicial Center, 1972), 57 F.R.D. 573, 602.

> . . . to afford immediate review in this Court in civil actions to which the United States or its officers are parties and thus will be bound by a holding of unconstitutionality. *Id.*

Obviously, Congress contemplated that as short a time period as possible would elapse from the time when a district court held a statute unconstitutional to the time when the Supreme Court would review the case. In addition to explaining why this Court's jurisdiction under Section 1252 is not subject to the limitations on direct appeal to this Court under Section 1253, the *McLucas* Court also emphasized the broad scope of review available under Section 1252, reiterating the principle that it had jurisdiction to review all issues in the case. 421 U.S. at 31.

Since the jurisdictional statute under which the instant appeals have been brought has been substantially changed since the time of the decisions relied upon by plaintiffs, and, since this Court now more liberally construes its jurisdiction under the present statute in contrast to its former strict approach, the decisions in the *Union Trust* and the *Wilkinson* cases cannot be said to represent the current state of the law on the direct appeal jurisdiction of this Court. Similarly, they can no longer, if they ever did, stand as authority for the proposition that this Court has no jurisdiction to review the statutory issues which were before the Seventh Circuit. This Court has consistently held that it must first review statutory issues which might provide alternative grounds in support of a decision before reaching difficult constitutional issues such as the one in this case. If the Court accepts plaintiffs' arguments regarding the scope of the appeal, it will be compelled to disregard the rule and to consider the constitutional issues head on, without the benefit of a clarification of the issues that a resolution of the statutory questions may provide. That would serve to undermine the interrelated purposes of both the principle against unnecessary constitutional adjudication and Section 1252: to permit full and effective review in this Court of all issues in a

case where a federal statute has been invalidated. It is respectfully submitted that this Court should find that it has jurisdiction to review all issues presented, including the statutory questions which were before the Court of Appeals.

II.

FROM *ROE* v. *WADE* TO P.A. 80-1091: ABORTION FUNDING LIMITATIONS AND LEGISLATIVE PURPOSE

Since shortly after its admission into the Union in 1818 to July 19, 1973, Illinois maintained a public policy, patterned after English common and statutory law, of outlawing abortions except when necessary to preserve the life of the mother. ILL. REV. STAT. ch. 38, § 23-1 (1961); REV. STAT., p. 348, div. I, par. 3 (1874); Laws of 1867, p. 89, secs. 1, 2, 3; REV. STAT. p. 158, sec. 46 (1845).

This was the state of the law in Illinois in 1965 when Congress added a new Title XIX to the Social Security Act, Pub. L. 89-97, 79 Stat. 343 (commonly known as the "Medicaid" program) and Illinois opted to participate as a fiscal partner in the new program.

Prior to its repeal in 1973, section 23-1 was construed by the Illinois Supreme Court in *People ex rel. Hanrahan* v. *White*, 52 Ill. 2d 70, 285 N.E.2d 129 (1972). The Court was asked to determine whether section 23-1(b) included "not only physical but psychiatric grounds as an affirmative defense" to felony prosecutions authorized under section 23-1(a). *Id.* at 72, 285 N.E.2d at 130. In an opinion based upon an analysis of legislative history, the Court held that "grounds for a legal therapeutic abortion" in Illinois did not include the concept of mental or psychiatric grounds. *Id.* at 73-74, 285 N.E.2d at 131. In so ruling, the Court reaffirmed that public policy in Illinois has always been to limit "performance of a therapeutic abortion for the preservation of a woman's life due to physical dangers." *Id.* at 73, 285 N.E.2d at 130. The Court expressly noted that

the legislature had contemplated, but rejected, an amendment to section 23-1 to legalize "physical or mental health impairing abortions." This was sufficient for the Court to conclude that there existed a "definite legislative history and rational basis" for excluding psychiatric, and by necessary implication, physical health impairing grounds from consideration as "necessary for the preservation" of the female's life. *Id.* at 75, 285 N.E.2d at 131.

In the wake of this Court's decisions in *Roe* v. *Wade*, 410 U.S. 113 (1973) and *Doe* v. *Bolton*, 410 U.S. 179 (1973), the Illinois Legislature enacted P.A. 78-225, effective July 19, 1973 ILL. REV. STAT. ch. 38, § 81-11 *et seq.*). The new law was intended to implement the ruling in *Roe* v. *Wade* that the Constitution was a bar to the imposition of criminal sanctions and other access-barring requirements for abortions. It was also designed to take cognizance of the competing interests inherent in any abortion decision, including the woman's qualified right to privacy, the state's interest in maternal health and childbirth, and the protection to be accorded potential human life, by regulating the conditions under, and purposes for which, abortions may be performed, § 81-14.

In 1975, the Illinois legislature enacted a new criminal abortion act, P.A. 79-1126, ILL. REV. STAT. ch. 38, § 81-21 *et seq.* (Supp. 1976) which imposed, *inter alia*, spousal and parental consent requirements as conditions to the performance of any legal abortion. In a preface to the Act, the Illinois General Assembly declared its avowed intention in enacting the measure and set forth a clear statement of the policy of the state respecting fetal life:

§ 81-21. *Legislative Intention*

> It is the intention of the General Assembly of the State of Illinois to reasonably regulate abortion in conformance with the decisions of the United States Supreme Court of January 22, 1973. Without in any way restricting the right of privacy of a woman or the right of a woman to an abortion under those decisions, the General Assembly of the State of Illinois do solemnly declare and find in reaffirmation of the long-standing policy of this State, that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception under the laws and the Constitution of this State. Further, the General Assembly finds and declares that longstanding policy of this State to protect the right to life of the unborn child from conception by prohibiting abortion unless necessary to preserve the life of the mother is impermissible only because of the decisions of the United States Supreme Court and that, therefore, if those decisions of the United States Supreme Court are ever reversed or modified or the United States Constitution is amended to allow protection of the unborn then the former policy of this State to prohibit abortions unless necessary for the preservation of the mother's life shall be reinstated.

Although several provisions of the 1975 Act were struck down as unconstitutional, *Wynn* v. *Scott*, 449 F. Supp. 1302 (N.D. Ill. 1978), *appeal dismissed*, 439 U.S. 8 (1978), *aff'd sub nom.*, *Wynn* v. *Carey*, 599 F.2d 193 (7th Cir. 1979), § 81-21 was left unaffected and is still a statement of the policy of the state of Illinois respecting the value it assigns to fetal life.[20]

While the *Wynn* case was pending, this Court issued its trilogy of decisions dealing with the issue of state funding of abortions for indigent woman under medical assistance programs for the poor. *Beal* v. *Doe*, 432 U.S. 438 (1977); *Maher* v. *Roe*, 432 U.S. 464 (1977); and *Poelker* v. *Doe*, 432 U.S. 519 (1977).

---

[20] The Illinois General Assembly recently enacted legislation overriding Illinois case law precluding institution of a cause of action for wrongful death of a fetus unless the fetus was viable at the time of injury. *Green* v. *Smith*, 71 Ill.2d 501, 377 N.E.2d 37 (1978). P.A. 81-946, amending ILL.REV.STAT. ch. 70, adds a new paragraph 2.2 which now provides a cause of action for the wrongful death of a non-viable fetus. *See*, 6 ILL. LEGISL. SERV. 2295 (1979)

Against the background of these decisions as well as in response to Congressional initiatives to limit abortion funding for eligible recipients of medical assistance under Title XIX of the Social Security Act, Pub. L. 94-439, Section 209, 90 Stat. 1418 [the original Hyde Amendment], the Illinois General Assembly took up the debate of House Bill 333, a proposed amendment to Articles V, VI and VII of the Illinois Public Aid Code. ILL. REV. STAT. ch. 23, § 1-1 *et seq.* (Supp. 1977), designed to limit the expenditure of state funds for the performance of any abortion under the Public Aid Code except where "necessary for the preservation of . . . life."

The debates on House Bill 333 (reproduced in full in the separately-bound Joint Appendix, at 42-88) demonstrate the deeply-felt and diverse opinions of the elected representatives of the people of the state concerning affirmative state involvement in, and subsidization of, the performance of abortions in a manner contrary to the State's avowed public policy to protect fetal life.

The following excerpts from the debates illustrate that the supporters of House Bill 333 intended to discourage the unnecessary destruction of fetal life by the withdrawal of state subsidization of non-"life preserving" abortions.[21] Abortion was seen as a unique procedure, rarely necessary on purely physical, life-threatening grounds. Still, it was acknowledged that the final arbiter of the circumstances justifying an abortion "necessary to preserve . . . life" was without question the physician, and not the legislature:

---

[21] The members of the General Assembly were debating over the enactment of a "life-preservation" standard. However, different terms were mentioned, depending upon the speaker, for those abortions which were to be funded and which were not to be funded. For example, some legislators used the "therapeutic/non-therapeutic" distinction; others referred to "medically necessary/non-medically necessary" abortions. It is clear from the debates as a whole that reference to "medically necessary" abortions evidenced no intent to fund "medically necessary" abortions as defined by the plaintiffs or the district court, i.e., the *Doe* v. *Bolton* definition. *See* Part III, *infra*.

Representative Leinenweber:

> " . . . [T]he issue is, 'as a matter of public policy of the State of Illinois . . . to pay for abortions that are not medically necessary'. Conceding that . . . the woman's right to privacy is broad enough to include the decision whether to abort. It does not follow that the taxpayers must pay to enable her to fulfill this right. We have many rights guaranteed under the Constitution . . . The State, through its exercise of public policy, decides what right it should fund. . . . The state currently makes no pretense of paying for any and all procedures. . . . There are millions of Illinois taxpayers who believe deeply that nontherapeutic abortions are morally objectionable. These feelings are to be recognized in the public policy of this state . . . "
>
> Illinois House of Representatives, Transcript of Debate on House Bill 333 (May 4, 1977), App. 42, 43.

Representative Bradley:

> " . . . [N]owhere in the Supreme Court's 1973 abortion decision did that majority . . . assert that the right to be free from legal restraints in deciding on . . . and obtaining an abortion, carried with it a duty on the part of the state to pay for the abortion when a pregnant women could not afford one. The expressed will of Congress . . . in the so-called Hyde Amendment . . . that the Federal Government . . . is not to pay for abortions . . . with tax moneys . . . Also, Ladies and Gentlemen of the House, pregnancy is not an illness. An abortion is not just another medical procedure. It is an elective surgery undertaken to relieve stresses which are nearly always social, economic or psychological. Seldom physical to the point of threatening a pregnant woman's life. . . . "
>
> Illinois House of Representatives, Transcript of Debate on House Bill 333 (May 4, 1977), App. 43, 44.

Senator Lemke:

> "If the . . . if the medical personnel at that hospital, of any hospital, determines that this is a . . . that she is in need of a therapeutic abortion, which is a medical determination

and is not my determination, she can have it. . . ."

Illinois Senate, Transcript of Debate on House Bill 333 (June 27, 1977), App. 60.

Representative Duester:

"Very briefly, Ladies and Gentlemen of the House, the question is not here anything to do with individual rights. This legislation does not grant, expand or limit or take away anybody's individual rights. What this legislation does is simply establish the public policy that the people expect to establish in the State of Illinois with respect to the attitude toward life and toward the attitude of what some of us don't like to refer to by what it really is is the killing of unborn children. We are not taking away the Constitutional Rights that have been recognized by the Supreme Court. An individual person anywhere in the State of Illinois can choose to terminate a pregnancy or have that child in the womb killed. What we are doing is saying, 'We're not going to promote it, we're not going to subsidize it, we're not going to reach into the pockets of the taxpayers of Illinois and force them to pay for something that they think is wrong and they think that's something that should be discouraged as a matter of public policy.' The rights remain, what we're doing here is not subsidizing and promoting that practice."

Illinois House of Representatives, Transcript of Debate on House Bill 333 (November 3, 1977), App. 81.

As the legislators frequently spoke of the decision of this Court in *Maher* v. *Roe* and noted the passage of the Hyde Amendment, it is difficult to avoid the conclusion that the Illinois General Assembly viewed those federal developments as essentially altering the obligations of the State of Illinois under its Title XIX program and justifying amendments to the Illinois Public Aid Code paralleling those federal initiatives.

With this historical perspective of state policy and legislative purpose in mind, we turn to a discussion of the concept of "medical necessity" as it relates to pregnancy and abortion in the practice of medicine.

III.

ABORTION FUNDING LIMITATIONS AND THE PRACTICE OF MEDICINE: BIOETHICAL CONSIDERATION, THE CONCEPT OF "MEDICAL NECESSITY", AND MEDICAL ALTERNATIVES TO ABORTION.

[Abortion] involves the most basic and volatile principles about which men can differ: life, death, liberty, privacy, our traditions, our ideals, our moral values.

Byrn v. *New York City Health & Hospital Corp.*, 38 App. Div. 2d 316, 324, 329 N.Y.S. 2d 722, 729, *aff'd*, 31 N.Y. 2d 194, 286 N.E.2d 887, 335 N.Y.S. 2d 390 (1972)

The phrase "between a woman and her physician" is an empty one since the physician is only the instrument of her decision, and has no special knowledge of the moral dilemma or the ethical agony involved in the decision. Furthermore, there are seldom any purely medical indications for abortion.

B. NATHANSON, ABORTING AMERICA 166 (1979), originally at 291 *New England Journal of Medicine* 1189, 1190 (November 28, 1974)

Judge Grady's decision below relied heavily and uncritically upon the affidavits of certain physicians. These affidavits discuss the alleged effect of P.A. 80-1091 and the Hyde Amendment standards on the physicians' professional medical training and judgment respecting the complications of pregnancy and abortion. It is not so much what these physicians say regarding the possible complications of pregnancy and statistics on morbidity and mortality. It is, rather, what they fail to say about the competence of the medical profession to successfully live up to their obligation to treat *both* of their patients, the fetus as well as the mother, in accordance with normal standards of care the law holds them to whenever it reviews the reasonableness of their professional activities. Judge Robinson, speaking for the Court of Appeals for the District of Columbia

in a medical malpractice case involving the failure of a physician to reasonably inform an ailing patient as to the treatment alternatives available and the risks incidental to them, succinctly stated what duty of care the law imposes upon physicians:

> '[T]he yard stick is that degree of care which a reasonably prudent person would have exercised under the same or similar circumstances.' 'Beyond this' . . . 'the law requires those engaging in activities requiring unique knowledge and ability to give a performance commensurate with the undertaking.' Thus physicians treating the sick must perform at higher levels than non-physicians in order to meet the reasonable care standard in its special application to physicians—'that degree of care and skill ordinarily exercised by the profession in [the physician's] own or similar localities.' *Canterbury* v. *Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972) (citations omitted).

Despite this long-standing standard of care to which the law holds physicians, and which as applied to the professional evaluation of medical risks translates as the rendering of professional judgment based upon a "reasonable" medical certainty, Oren Richard Depp, III, M.D., and other physicians insist that P.A. 80-1091 and the Hyde Amendment standards impose upon them a standard of "predictive certainty" and requires "physicians to make absolute judgments which they have been taught they cannot make." Affidavit of Depp, App. 109, ¶ 15. Confident in this medicolegal opinion, Dr. Depp asserts, and the District Court found, that the effect of the Hyde Amendment standards "will be to increase substantially maternal morbidity and mortality among indigent pregnant women." App. 111, ¶ 18; *Zbaraz* v. *Quern*, 469 F.Supp. 1212, 1219-1220.

Plaintiffs' ideological manipulation of medical concepts and legal requirements is not supported by standard medical texts. These texts carefully distinguish between ethical, legal

and purely medical considerations attending the treatment of pregnancy-related medical problems and the performance of abortions and do not attempt to impose a simplistic reductionism to statistical data upon complex bioethical questions. S. ROMNEY et al., GYNECOLOGY AND OBSTETRICS—THE HEALTH CARE OF WOMEN 34 (1975) [hereinafter cited as ROMNEY].

The aim of obstetrics "is that every pregnancy be wanted and culminate in a healthy mother and a healthy baby." WILLIAMS, OBSTETRICS 2 (15th Ed. 1976) [Hereinafter cited as WILLIAMS]. Pregnancy *per se* is not a disease. The classic definition of disease is that it is "a condition which, if not combatted, leads to further degeneration and death." ROMNEY, 34. Plaintiffs' notion of disease "is based more directly on statistical predictions of mortality and morbidity," *Id.* at 35, "even in the absence of presenting complaints by patients." *Id.* "Thus, the question [posed by the affidavits is] whether society decides that services should be rendered by 'health care' personnel on some ground other than the classical definition of 'disease' ". *Id.*

Medical science recognizes that with respect to abortion there is a considerable amount of controversy and uncertainty, especially regarding the ethical obligations of a treating physician who by definition has *two* patients:

> "The notion that prior to 12 or 13 weeks abortion is safer than childbirth in terms of maternal mortality statistics is a questionable means of assessing the 'value' of fetal life, since it assigns a zero value to the child. In other words, it is methodologically questionable whether the value of a biological entity can be assessed by an analysis of the safety of a technical procedure. Yet others would assign little or no value to a fetus or a child at all unless it was capable of certain functions such as thought, interpersonal relationships, the giving and receiving of love, or some other putative criterion of humanity. Similar debates and forms of argumentation occur about the 'quality of

life' or the nature of 'meaningful life' at its end as at its beginning. In brief, the debate is between biological and relational definitions of life.

Quite separate from these debates is the question of how one is to act when one does not know the answers to the questions under discussion. Who makes the final decisions? Here, separate ethical issues are raised. When in doubt, how should one act: presumptively in favor of life for the fetus? Presumptively in favor of maternal (and/or paternal) decision making? In favor of physician decision making? Suffice it to say that expertise in ethical decision making is not based on what are commonly asserted to be professional insights but rather on value assessments." ROMNEY, 37.

Plaintiff Jane Doe, according to Dr. Zbaraz, presented a "history" of varicose veins, as distinguished from presently existing varicosities. (App. 92) The varices of pregnancy are not a disease "specific to pregnancy", ROMNEY, 713, but are rather a disease "complicating pregnancy", ROMNEY, 794-795. Treatment of varicosities does not include abortion and "is generally limited to periodic rest with elevation of the legs, or elastic stockings, or both. Surgical correction of the condition during pregnancy is usually not advised." WILLIAMS, 260-261.

Based upon a prior history of "thrombophlebitis",[22] Dr. Zbaraz concluded that (1) her varices "were almost certain to recur"[23] and (2) there existed "about a 30% risk that her thrombophlebitis will recur during the pregnancy in the form of 'deep vein' thrombophlebitis." App. 92. While acknowledging in one breath that there was an available alternative mode of

[22] Thus, Plaintiff Doe did not have *present* symptoms of the disease, only a prior history.

[23] It is ironic that physicians who rail against the "predictive certainty" imposed upon them by P.A. 80-1091 can make nearly absolute medical judgments about what will occur in the future for a patient based upon abstract statistical data. Physicians treat patients on a case by case basis, not abstract populations based wholly on statistical predictions.

treatment, namely "bed rest", Dr. Zbaraz avers that in his medical judgment "an abortion is necessary for her, though not necessary to preserve her life." *Id.* What Dr. Zbaraz failed to state is that superficial "thrombophlebitis" rarely, if ever, necessitates an abortion, and that the condition is adequately managed by the administration of "heparin" a medication which prevents the formation of blood clots and is routinely and safely administered during pregnancy. WILLIAMS, 770, 772.

Moreover, the Court should take note of the fact that Dr. Zbaraz carefully did *not* state that Plaintiff Doe, upon examination, presented symptons of "deep vein" thrombophlebitis, which is a disease that carries a serious risk of pulmonary embolism, a potentially fatal complication. Nor did he mention that absent the occurrence of a pulmonary embolism that "deep vein" thrombophlebitis is treatable with antibiotics (if accompanied by inflammation), analgesia, elastic stockings and heparin. WILLIAMS, 771. And Dr. Zbaraz fails to explain why he could not certify an actual occurrence of "deep vein" thrombophlebitis as a condition warranting an abortion "necessary for the preservation of . . . life" given the serious risk of a pulmonary embolism that accompanies that disease when it in fact strikes.

There is nothing in the record in this case that indicates that the State of Illinois expects Medicaid physicians to conform to some standard of medical practice or standard of care which differs from their training or imposes upon them, through the enforcement of P.A. 80-1091, concepts foreign to their profession. All Illinois expects is that a physician, who believes that an abortion for a patient is "necessary for the preservation of [her] life", certify that fact based upon a "reasonable medical certainty." This is the standard to which physicians are routinely held by the law when their professional activities become subject to legal scrutiny. *See*, Affidavit of Kenneth Wilson, (App. 136), disclaiming any suggestion that the state agency

second-guesses the certifications of physicians that an abortion falls under the ambit of P.A. 80-1091, absent some other indication for review, such as evidence of fraud.

This is the same position that the Department of Health, Education and Welfare took when it promulgated regulations to the Hyde Amendment. 43 Fed. Reg. 31876 (July 21, 1978). The comments of the federal agency make clear that, within the scope of abortions which will be funded, it is the physician who is the final arbiter of the "life preserving" standard:

> . . . [A]n analysis of the legislative history . . . coupled with the history of the Department's administration of the abortion limitation in the 1977 HEW appropriations act . . . dictate that these decisions must be left to physicians on an individual basis. It would be inappropriate . . . to specify the factors that physicians should take into account in making the determinations, or to spell out in greater detail the meaning of the terms . . . the Department must rely on these physicians to utilize their best medical judgment. 43 Fed. Reg. 31876 (July 21, 1978).

Against this analysis, the Court should examine the concept of "medical necessity" which Plaintiffs have taken from *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973) and inappropriately inserted into the abortion funding issue. A concept of "medical necessity" which permits a physician in making professional judgments to take into account "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient" is, defendant respectfully submits, antithetical to the intent of Congress that states participating in the Medicaid program have wide latitude in establishing "reasonable standards . . . for determining eligibility for and the extent of medical assistance" under its state plan. 42 U.S.C. § 1396a(a)(17). The objectives of physicians like Dr. Depp appear to transcend the purely medical realm when he asserts that "the percentage of abortions any physician would deem 'medically necessary' is likely to fall between 20% and 50% of representative cases in which the pregnant woman

wants an abortion." Depp affidavit, ¶ 11, App. 107. *See also,* Affidavit of Peter Barglow, M.D., ¶ 10, App. 118 ("I would estimate that approximately 25% of a group of low income, pregnant women . . . have a psychiatric need for abortion"); ¶ 11, App. 118 ("I would estimate that approximately 35% of a group of low income, pregnant adolescents would, after examination, be judged to have a psychiatric need for an abortion.").[24]

Not every physician who specializes in obstetrics and gynecology is prepared, under the guise of "medical necessity," to ignore so readily as plaintiffs his ethical obligations to his *other* patient or be so reticent about clinical intervention for the purpose of treating the complications of pregnancy without recourse to abortion except where palpably necessary. One physician, whose bioethical perceptions have been transformed as the result of his deep personal involvement in the effort to legalize abortion and provide abortion services, makes a well-reasoned plea to his colleagues for the acceptance of a medically sophisticated and flexible life-preservation standard for the performance of abortions. B. NATHANSON, ABORTING AMERICA 242-247 (1979), reproduced in the addendum hereto at Add. 79a-84a. [hereinafter cited as NATHANSON].

"The list of indications [which satisfy Dr. Nathanson's life-preservation standard of necessity] *cannot be etched in stone;* it varies by medical knowledge." NATHANSON, 243 (Add. 79a). "There must . . . be a reasonable probability that the coexistence of pregnancy [and diseases complicating pregnancy] will materially and significantly shorten the mother's life" or

---

[24] In debating the 1978 version of the Hyde Amendment the Senate proposed to limit abortion funding except where "medically necessary." 123 Cong. Rec. S 11051 (daily ed. June 29, 1977). Opponents rejected this language as being tantamount to abortion on demand. 123 Cong. Rec. S 11054 (Sen. Domenici) (daily ed. June 29, 1979); 123 Cong. Rec. S 13671 (Sen. Schweiker) (daily ed. Aug. 4, 1977).

that "pregnancy raises the risk of imminent death." NATHANSON, 244 (Add. 81a). Dr. Nathanson rejects the invocation of "medical indications" without more as sufficient justification for an abortion since such an approach is so inherently elastic as to encompass all *elective* abortions within its ambit. At the heart of Dr. Nathanson's argument there is a respect for the sanctity of life which leads him as a medical professional to believe that the taking of fetal life is not medically justified except where reasonably and palpably necessary to preserve the mother's life.

Through its normal democratic processes, Illinois has reached the same conclusion. By enacting P.A. 80-1091, the State requires Medicaid physicians, as a condition of receiving public funds, to take reasonable measures to treat the complications of pregnancy without recourse to abortion except where the physician can certify, to a reasonable medical certainty, that aborting the fetus is palpably necessary to preserve maternal life from a risk materially posed by the coexistence of the pregnancy and disease complicating pregnancy. This is a fair interpretation of the state law based upon the legislative history of P.A. 80-1091, the review and reimbursement policies of the state agency charged with enforcing the act, and the legal standard of care and certainty to which all physicians are held by the law when their activities are subject to judicial scrutiny.

The question then posed is whether plaintiffs have a claim of statutory entitlement to all "medically necessary" abortions under Title XIX of the Social Security Act without regard to the bioethical consideration underlying P.A. 80-1091, the availability of state funds for alternative modes of treatment and the limitations placed upon state discretion by congressional enactment of the Hyde Amendment.

IV.

TITLE XIX OF THE SOCIAL SECURITY ACT DOES NOT ENTITLE INDIGENT WOMEN OR THEIR PHYSICIANS PUBLIC FUNDING FOR ALL ABORTIONS DEEMED "MEDICALLY NECESSARY"

The Seventh Circuit Court of Appeals in *Zbaraz II*, adopting the reasoning of the First Circuit in *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979), *cert. denied.*, ____ U.S. ____, 99 S.Ct. 2181 (1979), concluded that without regard to the Hyde Amendment, Title XIX of the Social Security Act prohibited states from singling out "medically necessary" abortions as a procedure which the states could refuse to fund except in narrow circumstances. Although both courts went on to hold that the Hyde Amendment was a substantive modification of Title XIX and relieved participating states of the obligation to fund "medically necessary" abortions falling outside the Hyde Amendment categories, Defendant Miller respectfully suggests that these courts erred in their reading of basic Title XIX requirements and their treatment of abortion as comparable to other medical and surgical procedures. Defendant believes that a review of the express terms, implementing regulations and legislative history of the federal statute will demonstrate that without regard to the passage of the Hyde Amendment, States are free to reasonably limit the scope of their Title XIX state plans and exclude care and services which medical providers might imagine to be necessary. Furthermore, since only the procedure of abortion involves the termination of potential human life, placing restrictions on the funding of this unique procedure is a rational means by which a state can protect its interest in fetal life.

A.

Title XIX Does Not Require State Funding Of All "Medically Necessary" Procedures.

This case poses, as a threshold matter, the "serious statutory questions" left unanswered in *Beal* v. *Doe*, 432 U.S. 438 (1977): whether a state Medicaid plan which excludes "necessary" medical treatment from its coverage is consistent with the express terms of Title XIX. As recognized by Mr. Justice Powell in *Beal* the "starting point in every case involving construction of a statute is the language itself," *Beal* v. *Doe*, *Id.*, at 444.

Defendant Miller does not interpret Title XIX as imposing upon Illinois an obligation to fund all conceivable health care or medical services which a medical provider deems to be "medically necessary" or "medically indicated". Medicaid is not a welfare program for providers. Within broad federal guidelines, Medicaid is a state-structured, non-comprehensive program for providing medical services to the indigent with the state determining the amount, duration and scope of the services and care to be provided.[25]

---

[25] In 1965, Congress added a new Title XIX to the Social Security Act, Grants to States for Medical Assistance Programs, Pub. L. No. 89-97, 79 Stat. 343 (1965) (Codified at 42 U.S.C. §§ 1396 *et seq.* (1976) and commonly called the "Medicaid" program). Title XIX was intended by Congress to improve and extend the 1960 Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons. S. Rep. No. 404 to Pub. L. 89-97, 1965 U.S. CODE CONG. & AD. NEWS, 1950.

The legislative history of the Act discloses that Congress was cognizant that the program it was establishing was less than comprehensive and that federal financial participation in this new, joint federal/state program was only intended at the beginning to "assure a consistent statewide program at a reasonable level of adequacy." *Id.* at 2015. Congress believed that within ten (10) years, i.e., by 1975, participating states would then be in a position to make substantial "efforts toward broadening the scope of care and services made

(Footnote continued on next page.)

This program of "co-operative federalism," described briefly in Part I, *supra*, imposes certain mandatory requirements upon states such as Illinois, which have elected to participate. As a prerequisite to federal funding under the Act, a state Medicaid plan must provide financial assistance in five general categories of medical services.[26] 42 U.S.C. §§ 1396a(a)(13)

(Footnote continued from preceding page.)

available under the plan," *Id.*, at 2025, and to that end, Congress included a statutory provision limiting federal financial participation to any state failing to provide needy persons comprehensive care by 1975. *See*, Grants to States for Medical Assistance Programs, Pub.L. No. 89-97, § 1903(e), 79 Stat. 349 (1965) (codified as 42 U.S.C. § 1396b(e)).

Arguably, under a comprehensive Medicaid program, participating states such as Illinois would have little discretion or leeway to define standards of medical need or to refuse to fund any conceivable medical procedure so long as the welfare patient's physician deemed the care medically necessary and federal funding was available for the care. However, whatever Congress intended by the inclusion of § 1396b(e) in the 1965 statute, its concept of what the Medicaid program should be was altered in 1972 when it repealed § 1396b(e) *in toto* by the passage of Act of Oct. 30, 1972, Pub. L. 92-603, § 203, 86 Stat. 1410. To date, no subsequent amendments of Title XIX have contemplated a return to the goal of comprehensive care. What remains of the original intent, therefore, is delivery of "adequate" care under a federal/state scheme wherein individual states have a great deal of discretion and leeway in determining the manner and extent to which they will provide medical assistance to needy persons.

In §§ 278(a)(21) and 299E(b) of the 1972 Amendments, Congress added a clause mandating the provision of "family planning services and supplies." 42 U.S.C. § 1396d(a)(4)(C). Congress could have taken this opportunity to require states to fund all therapeutic abortions but it did not. As noted by the Court in *Beal* v. *Doe*, 432 U.S. 438, 447 n. 10, "The failure to exclude abortions from coverage [in § 1396d(a)(4)(C)] indicates only that Congress intended to allow such coverage, not that such coverage is mandatory."

[26] The five general categories are: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing facility services, periodic screening and diagnosis of children, and family planning services; and (5) physician's services.

(B) and 1396d(a)(1)-(5). As to these five categories of services, all that is required is that the state plan include "reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . consistent with the objectives of [Title XIX]." 42 U.S.C. § 1396a(a)(17).

Medical assistance, as defined in 42 U.S.C. § 1396d(a), must be provided to all eligible individuals. 42 U.S.C. § 1396a(a)(8). Illinois extends medical assistance to both the categorically needy, 42 U.S.C. § 1396a(a)(10)(A), a mandatory requirement, and the medically needy, 42 U.S.C. § 1396a(a)(10)(C), an optional requirement. *See, Beal* v. *Doe, supra,* 432 U.S. at 440 n. 1.

Beyond these minimal state plan requirements, the States electing to participate have wide latitude to determine the amount, duration and scope of medical assistance which eligible individuals are entitled to receive: "[N]othing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care." *Id.,* at 444.

Congress expressly reposed substantial discretion in participating States in 42 U.S.C. § 1396 which provides, in part:

> § 1396. *Authorization of appropriations*
>
> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter.

Contrary to the assertions of the plaintiffs below, the language of § 1396 does not evidence an intent by Congress to mandate state funding of all "necessary medical services." Neither the First Circuit in *Preterm, Inc.* v. *Dukakis, supra,* 591 F.2d at 124,

nor the Seventh Circuit in *Zbaraz II, supra,* 596 F.2d at 198-199, accepted the argument that the term "necessary medical services" was intended to qualify the term "medical assistance." Rather, the language which plaintiffs have seized upon, was meant to identify those individuals for whose benefit federal funds are to be appropriated. *Roe* v. *Norton,* 522 F.2d 928, 933 (2d Cir. 1975).

The term "medical assistance" is defined in 42 U.S.C. § 1396d(a) to mean payment "of part or all of the cost" of the services which a state incorporates in its state plan. § 1396d(a) nowhere mentions "necessary medical services," and authorization by Congress for states to pay "part" of the cost of, for example, physician's services suggests strongly that medical providers were not intended to be the final arbiters of what a state plan may or may not include.[27]

Additional evidence of state discretion is reflected in § 1396a(a)(10) which requires comparable treatment among categorically and medically needy recipients. § 1396a(a)(10) provides, *inter alia,*

> (A) for making *medical assistance* available to [the categorically needy] . . . [which] . . .
>
> (B) . . . (i) shall not be less in *amount, duration, or scope* than the medical assistance made available to [the medically needy] . . . (emphasis added)

---

[27] Even if the Act contained a requirement that States provide "medically necessary services," the term eludes precise definition by taking on different shades of meaning depending upon the context referred to, such as, the meaning intended by Congress, by individual participating states, by the medical community, or the meaning imparted by constitutional analysis over a broad spectrum of factual situations. *See* discussion in *D* ____ *R* ____ v. *Mitchell,* 456 F.Supp. 609, 620-624 (D. Utah 1978).

The phrase "amount, duration and scope" is repeated six times in § 1396a(a)(10) and is repeated several more times in the statute. *See*, § 1396a(a)(14), § 1396a(f), § 1396b(a)(1) and § 1396d(a). The Act nowhere defines what is meant by "amount, duration, or scope" of "medical assistance" and it must be concluded that each state has wide latitude, subject only to § 1396a(a)(17), in establishing standards of medical assistance which may reflect limitations by "amount, duration, or scope" of the care and services to be provided under the state's plan.[28]

The practice of the Secretary of the United States Department of Health, Education and Welfare who has approved Title XIX state plans which vary widely in the specifications of covered services and types of limitations on benefits for which funds are available is in accord with this interpretation of the Act. *See*, 2 CCH *Medicare and Medicaid Guide* ¶ 15,501 *et seq.*, and particularly ¶ 15,582 for the State of Illinois. The Secretary has approved the Illinois State plan and the Illinois Department of Public Aid (I.D.P.A.) has promulgated detailed rules and regulations for medical providers which identify the exclusions and limitations applicable to the service categories incorporated in the State's plan. In the Addendum to this brief I.D.P.A.'s general rules applicable to all providers and specific rules for physicians and hospitals are set out in pertinent part. (Add. 7a-67a).

---

[28] In *Virginia Hospital Association* v. *Kenley*, 427 F. Supp. 781 (E.D. Va. 1977), the court upheld a Virginia regulation which limited Medicaid reimbursement for hospital visits to a total of 21 days per year. Judge Merhige held that such limits were not violative of either the comparability requirements of 42 U.S.C. § 1396a(a)(10) or the best interest requirements of 42 U.S.C. § 1396a(a)(19). The court found that, even though some recipients required "medically necessary" hospital treatment in excess of 21 days, Virginia's limit was justifiable under the broad standard of discretion states have to allocate their available Medicaid funds "as far as practicable" under 42 U.S.C. § 1396. The court also held that under applicable federal regulations [42 C.F.R.§ 440.230] the state may set reasonable limitations in defining what services will be provided. *Id.* at 783-785.

ILL. MED. ASSISTANCE PROGRAM, Rule 102, *General Policy and Procedure*, provides, in relevant part, that "The Department reserves the right to determine the necessity of providing medical care." (Add. 7a.). Rule A-203, *Physician's Services*, defines "covered services" as "those reasonably necessary medical and remedial services which are recognized as standard medical care required because of illness, disability, informity, or impairment, and which are necessary for immediate health and well-being." (Add. 13a). Rule A-204 states the "Services for which medical necessity is not clearly established are not covered in the Medical Assistance Program," (Add. 13a), and thereafter lists nineteen items which are excluded from coverage. Rule A-205.1, *Termination of Pregnancy—Induced Abortions*, reflects the ruling of Judge Grady at issue on this appeal.

Defendant Miller respectfully submits that this analysis satisfactorily establishes that the Medicaid statute does not mandate the inclusion of all "medically necessary services" in a state Medicaid plan and that Illinois' plan reserves the right to make determinations of necessity.

B.

Neither Title XIX Nor Regulations of the Department of Health, Education and Welfare Require the Funding of All "Medically Necessary" Abortions.

The Court in *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979) found that Title XIX does not mandate the funding of every imaginable medical service, treatment or procedure deemed "necessary" by a medical provider. However, based upon its reading of 42 U.S.C. § 1396a(a)(17) and Department of Health, Education and Welfare (H.E.W.) regulation 42 C.F.R. § 440.230 (1978), the *Preterm* court concluded that

under Title XIX Massachusetts had no authority to limit "medically necessary" abortions to those "necessary to prevent the death of the mother" and cases of pregnancy resulting from forced rape and incest. 591 F.2d 121, 126-127. The Seventh Circuit agreed with the reasoning and conclusion of the *Preterm* court. *Zbaraz* v. *Quern, supra*, 596 F.2d at 198-199.

This reading of the Medicaid statute by the *Preterm* court, and its adoption in *Zbaraz* II, stemmed primarily from its interpretation of 42 C.F.R. § 440.230(c)(i). According to the terms of 42 C.F.R. § 440.200, H.E.W. intended the provisions of Subpart B of Part 440 to specifically implement the following statutory provisions: § 1396a(a)(10), regarding comparability of services; § 1396a(a)(13)(B) and (C), prescribing the amount, duration and scope of services to be provided[29]; § 1396a(a)(22)(D), assuring quality of services; and § 1396f, regarding religious beliefs.

Significantly, § 440.230 does not have as its stated purpose implementation of § 1396a(a)(17) of the Act which is the primary measure against which any state plan limitation must be tested. The language of § 1396a(a)(17) "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act." *Beal* v. *Doe, supra*, 432 U.S. at 444. Director Miller reads § 440.230 (a) as placing limits on the "amount and duration" of "medical assistance" which a state, *ab initio*, has determined to provide as part of "required service" pursuant to § 1396a(a)(17). Thus § 440.230 provides, in part:

> (a) The plan must specify the amount and duration of each service *that it provides*. (emphasis added)

The language in § 440.230 which the *Preterm* Court seized upon comes later in the regulation, and then, only with respect to services within the ambit of a state plan:

[29] It should be noted, however, that § 1396a(a)(13)(B) and (C) include no references at all to "amount, duration, or scope" of services to be provided.

> (c)(1) The medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 [for the categorically needy] and 440.220 [for the medically needy] to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

"Required service" as found in § 440.230(c)(1) is simply a reference to the broad general categories of services in 42 U.S.C. §§ 1396a(a)(13)(b) and 1396d(a)(1)-(5).[30] "Title XIX makes no reference to abortions, or, for that matter, to any other particular medical procedure." *Beal* v. *Doe, supra*, 432 U.S. at 444. Nowhere in the regulations is abortion mentioned as a "required service."

By disregarding the relationship between 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230, as set forth above, the Court in *Preterm* agreed with the plaintiffs there that "the limitations imposed by Massachusetts on abortion services render those services insufficient in "amount, duration and scope" to reasonably achieve their purpose, and that the limitations are based solely on the type of medical condition involved rather than on determinations of medical necessity." *Preterm, Inc.* v. *Dukakis, supra*, 591 F.2d at 126. The Court reasoned instead:

> It could perhaps be argued that the Massachusetts plan reserves abortion services to those in greatest need—women who will die without an abortion—and denies it to those who need it less—women who will suffer damage to their health, no matter how grievous, but who will survive without the abortion. But we do not believe that the Medicaid Act contemplates or sanctions anything

[30] In *District of Columbia Podiatry Society* v. *District of Columbia*, 407 F. Supp. 1259, 1265 (D.D.C. 1975), the court, interpreting 45 C.F.R. § 249.10(a)(5)(i) [re-codified as 42 C.F.R. § 440. 230], held that the regulation is "intended to give the states the discretion to 'specify the amount and duration of each item of medical care and services that will be provided.'" The court upheld the refusal to provide all podiatrist services under the District of Columbia's Medicaid program.

> so stark. When a state singles out one particular medical condition—here, a medically complicated pregnancy—and restricts treatment for that condition to life and death situations it has, we believe, crossed the line between permissible discrimination based on degree of need and entered into forbidden discrimination based on medical condition. *Id.*

In Part III, *supra*, Defendant Miller discussed the concept of "medical necessity" as it relates to the obligation of the states under Title XIX and the role of the Medicaid physician who is free and encouraged to provide alternative modes of treatment to health problems which are treatable during pregnancy without recourse to abortion. The *Preterm* Court's analysis fails to appreciate the uniqueness of pregnancy as involving the treatment of two patients, the uniqueness of abortion as being the only medical procedure which results in the termination of life, and the availability of alternative modes of treatment for health-impairing illness and disease occurring during a pregnancy and which are treatable without recourse to abortion.

Pregnancy is not a disease. A limitation on abortion funding is not a denial or reduction in the "amount, duration or scope" of a required service to a recipient "solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230 (c)(1). It is a limitation placed on a particular *procedure*, not a *required service*, "because" of the unique aspect of pregnancy and abortion involving as they both do fetal life, a legitimate and protectable state interest. If a state refused to provide funds for an abortion to an indigent pregnant women suffering from thrombophlebitis and *also* refused to provide her with medication to prevent the formation of clots or refused to pay for hospitalization or bed rest, then it could truly be said that the state limitation was "'unreasonable' and wholly '[in]-consistent' with the objectives of the Act", constituting "forbidden discrimination" under § 440.230. *Preterm, Inc.* v. *Dukakis*,

supra 591 F.2d 121, 126. However, since nothing in *Preterm* or in this case suggests that either Massachusetts or Illinois would refuse to fund alternative modes of treatment, or that fetal life is not a protectable state interest, the conclusion that abortion funding limitations constitute an *arbitrary* denial or reduction in the amount, duration or scope of a required service is unwarranted.

"Absent such a showing" the Court should not presume "that Congress intended to condition a State's participation in the Medicaid program on its willingness to undercut [its important interest in fetal life] by subsidizing the costs" of non-"life-preserving" abortions for indigent women who have health problems treatable without recourse to abortion by treatment and care which a state is willing to fund. *Beal* v. *Doe*, *supra*, 432 U.S. at 446.

Some physicians, despite the existence of alternative modes of treatment for pregnancy complications falling short of life-threatening circumstances, may not value fetal life to the same extent as does the state and may insist on exercising their professional prerogative to perform an abortion instead. That is the physician's right. However, to the extent that the physician is unwilling to perform the procedure without payment by the state, he has no right to use the doctor-patient relationship as a sword to compel the state to abandon its policy favoring fetal life. Illinois' refusal to indiscriminately fund all abortions deemed "medically indicated" or "necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment . . . exercised in the light of all factors relevant to her health" (R. 124) is a legitimate prerogative of the state in its administration of a non-comprehensive welfare program. The refusal to fund is not, without more, active state interference in the doctor-patient relationship. P.A. 80-1091 reasonably encourages childbirth over abortion without militating against maternal health. By its terms, Title XIX does not require otherwise.

V.

THE HYDE AMENDMENT ALTERS THE STATE'S DISCRETIONARY AUTHORITY UNDER TITLE XIX TO FUND ALL "MEDICALLY NECESSARY" ABORTIONS.

The United States Court of Appeals in *Zbaraz II* found that the 1978 and 1979 versions of the Hyde Amendment, Pub. L. 95-205, 91 Stat. 1460 [Add. 4a-5a] and Pub. L. 95-480, 92 Stat. 1586 [Add. 5a-6a], though enacted as part of annual appropriation measures, were properly interpreted as substantive modifications of the state plan requirements of Title XIX and its implementing regulations. *Accord, Preterm, Inc.* v. *Dukakis*, 519 F.2d 121 (1st Cir. 1979), *cert. denied, sub nom., Preterm, Inc.* v. *King*, ____ U.S. ____, 99 S.Ct. 2182 (1979). The *Zbaraz* Court rejected plaintiffs' contention that, as the Hyde Amendment was simply an appropriation measure affecting federal funding of abortions, Congress intended to shift the costs of subsidizing abortions to the states. As noted in Part IV(B), *supra*, Defendant Miller disagrees with the Court of Appeals' construction of Title XIX as requiring the funding of all "medically necessary" abortions. Thus while the *Zbaraz II* court viewed the Hyde Amendment as working a substantive modification to a *mandatory* provision of the Medicaid statute, Defendant Miller submits that the correct view is that the Hyde Amendment altered the State's *discretionary authority* under Title XIX regarding the funding of non-Hyde Amendment abortions.

A.

The Hyde Amendment Is Substantive Legislation Amending Prior Law.

As a general rule, repeal or amendment by implication of a prior substantive law is disfavored. *Morton* v. *Mancari*, 417 U.S. 535, 549 (1974); *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153, 98 S.Ct. 2279, 2299 (1978). However, if "the intention of the legislature to repeal [is] clear and manifest."

Posadas v. *National City Bank*, 296 U.S. 497, 503 (1936), and if "the earlier and later statutes are irreconcilable," *Morton* v. *Mancari, supra*, 417 U.S. at 551, then the new law results in the old law giving way.

The key is always to discern the intention of the legislature. While on its face, the Hyde Amendment may appear to be simply an appropriation measure (" . . . [N]one of the funds provided by this joint resolution . . . ", Pub. L. 96-123, Sec. 109), such an interpretation would arguably have the effect of "imposing an obligation on the states to fund the total cost of non-Hyde Amendment therapeutic abortions, a result not consonant with the basic policy of the Medicaid system." *Preterm, Inc.* v. *Dukakis, supra*, 591 F.2d at 128. Thus resort to the legislative history of the Hyde Amendment is required to ascertain what Congress intended to accomplish by enactment of this funding restriction. *Id.*

"A fair-minded reading of the lengthy and often highly emotional floor debates in both houses compels the conclusion that Congress intended to alter the scope of Title XIX in regard to abortions." *Zbaraz* v. *Quern, supra*, 596 F.2d at 200. During the debates "no one, whether supporting or opposing the Hyde Amendment, ever suggested that state funding would be required." *Id.* In the early debates surrounding Pub. L. 94-493, 90 Stat. 1432, 1434 (1976) Representative Schroeder, an opponent of the law, acknowledged the effect which the act would have upon the states:

> "Each of our States will suffer the consequences of the action we take here today—a burden they can ill afford. [referring to the greater costs of funding child birth].
>
> In addition, retention of the Hyde Amendment would interfere with existing State statutes on use of public funds for abortions. Forty-seven States and the District of Columbia now permit medicaid reimbursement for abortions, but the Hyde amendment would prevent them from following their own State laws and guidelines. The result would be administrative chaos and increased litigation. 122 CONG. REC. H 8635 (daily ed. August 10, 1976).

Were the Hyde Amendment simply viewed as an appropriation measure, there would have been no occasion for Representative Schroeder to speak of "interference" with state programs. Moreover, it may not be fairly argued that Congress as a whole was unaware of the fact the Hyde Amendment constituted substantive legislation. *Cf., Tennessee Valley Authority* v. *Hill, supra*, 98 S.Ct. at 2300. Both supporters and opponents of the amendment acknowledged that it would have a substantive impact.[31]

The question thus becomes what impact precisely did the Hyde Amendment have. Is the Hyde Amendment clearly irreconcilable with the prior provisions of Title XIX?

B.

The Hyde Amendment Is Irreconcilable With The Discretion Congress Vested In Participating States To Determine The Extent of Medical Assistance To Be Provided In A State Plan.

Under 42 U.S.C. § 1396a(a)(17), as originally enacted, Congress intended to grant participating states wide latitude in structuring their state plans and making determinations regarding the amount, duration and scope of medical assistance to be provided. If, prior to the Hyde Amendment, a state determined that abortions were to be provided under its state plan, nothing in the Medicaid statute was a bar to such services. By including a particular item in its state plan, Congress intended that the state would be entitled to federal reimbursement according to the statutory formula for the costs incurred in providing such care. 42 U.S.C. §§ 1396b(a) and 1396d(b).

---

[31] *See*, remarks of Congressman Hyde, at 123 CONG. REC. H 6083 (daily ed. June 17, 1977); *Id.* at 6088 (Rep. Eckhardt); *Id.* at 6090 (Rep. Mazzoli); 123 CONG. REC. S 11035 (daily ed. June 29, 1977) (Sen. Brooke) ("Mr. President . . . Such restrictions are a blatant case of legislating in an appropriations bill").

The Hyde Amendment is irreconcilable with 42 U.S.C. § 1396a(a)(17) because the effect of the amendment is to strip states of the discretionary authority granted them under the prior law insofar as abortion funding is concerned. While the Hyde Amendment leaves states free under state law to fund abortions, no state is free to include non-Hyde Amendment abortions in its Title XIX state plan and receive federal financial participation.

This conclusion is supported by the comments of Representative Schroeder, cited above, which accurately reflect the pre-amendment state of the law. States were permitted, but not required, to fund abortions. Withdrawal of federal funding "would prevent" funding of abortions not covered by the amendment under state Medicaid plans since the federal law would "interfere" with those plans.

Whether the legislators during the 1977 or 1978 debates realized that the Hyde Amendment was specifically irreconcilable with 42 U.S.C. § 1396a(a)(17) is difficult to say. Any uncertainty, however, appears to have vanished during the most recent debates over appropriations for the year ending September 30, 1980. Senator Jesse Helms, a proponent of Pub. L. 96-123, Sec. 109, 93 Stat. 923, stated:

> Mr. President, Congress enacted medicaid into law in 1965 when the vast majority of States declared abortion a crime except when needed to save the mother's life. Therefore, the medicaid title could not have been intended as a mandate to the States to fund "medically necessary" abortions beyond those necessary to preserve the mother's life. 125 CONG. REC. S 14496 (daily ed. Oct. 12, 1979).

Representative Donnelly made a similar observation:

> We do not intend to restrict the power of the States to refuse to pay for abortions to the extent they deem appropriate . . . The States are absolutely free to fund or refuse to fund abortions as they see fit, as they always have been. Whether the States fund or refuse to fund abortions is not a matter dictated by the Social Security Act or its

> regulations and, until such time as the Social Security Act is amended by Congress to require the States to fund abortions, the States are not required to do so. 125 CONG. REC. H 9885 (daily ed. Oct. 30, 1979).

See also, the statement of Senator Percy, an opponent, acknowledging that the Medicaid Act "does not even require a State to fund [abortions]." 125 CONG. REC.S S 9873 (daily ed. July 19, 1979).

Given the clear intent of Congress to substantively amend the scope of Title XIX with regard to abortions, and in view of the repugnancy between such a limitation and the freedom states otherwise have under § 1396a(a)(17) to determine the extent of medical assistance to be provided, Defendant Miller submits that the judicial criteria for finding a substantive statutory modification have been met.

C.

Congress Did Not Intend To Cause A Shifting Of The Costs Of All Non-Hyde Amendment Abortions To The States.

An alternative theory regarding the nature of the Hyde Amendment considered by the court below is that the Hyde Amendment, as an appropriation measure, only affects federal funding of abortions and has no substantive impact upon Title XIX state plan requirements found in 42 U.S.C. § 1396a *et seq.* The effect of this theory, if true, would be to work a shifting of the responsibility of funding all "medically necessary" non-Hyde Amendment abortions to the States on the assumption that Title XIX contains a requirement that mandates the funding of all "medically necessary" abortions. This cost-shifting rationale is wholly unsupported by the debates: "Nor is there any suggestion in the Congressional debates that the Hyde Amendment would alter the basic scheme of federal-state sharing of Medicaid expenses." *Zbaraz* v. *Quern, supra,* 596 F.2d at 200. Acceptance of the cost-shifting rationale necessarily requires a finding that Congress intended to repeal, *pro tanto,* §§ 1396b(a) and 1396d(b) which govern payments to the states. If this was the intent, Congress as a body was certainly not aware of it, and absent such awareness, no clear and manifest intent to repeal the basis of the federal-state compact can be found. *Tennessee Valley Authority* v. *Hill,* 437 U.S. 153, 98 S.Ct. 2279, 2299-2300 (1978).

This problem has been noted by commentators who have analyzed the various theories accepted by the lower federal courts in ruling on Hyde Amendment related litigation. One commentator's observations are particularly apt:

> The shifting responsibility theory conflicts with the concept of cooperative federalism. For example, in *Smith* v. *Ginsberg* [Civ. No. 75-0380 (S.D. W. Va. May 9, 1978)] the United States District Court for the Southern District of West Virginia issued an injunction requiring the state to pay for all medically necessary abortions under the *Bolton* test. The court stated that the unavailability of federal reimbursement did not obviate the state's obligation to provide funds for all necessary abortions. The holding in *Smith* places the states in the situation of having voluntarily become a part of the medicaid system, only to have the federal funds withdrawn. Terminating federal funds, which are the foundation of the medicaid program, produces hostile, not cooperative federalism. Under the shifting responsibility theory, Title XIX forces the states to spend their own money without hope of federal assistance. Thus, while federal officials refuse reimbursement, a state would be required to provide services that it considers contrary to public policy. Note, *Limiting Public Funds For Abortions: State Response To Congressional Action,* 13 SUFFOLK U.L. REV. 922, 951 (1979).

Given the total absence in the debates of any indication that the Hyde Amendment would shift to the states the burden of funding under Title XIX all abortions which the federal government refused to fund, this Court should reject any theory

which characterizes the Hyde Amendment as merely an appropriation measure affecting only one of the two partners in the fiscal partnership known as the Medicaid program.

Therefore, unless there is a constitutional right to a publicly funded abortion not "necessary for the preservation of the life of the woman seeking such treatment," plaintiffs' challenge to the validity of P.A. 80-1091 must fail.

VI

P.A. 80-1091 IS CONSISTENT WITH THE FOURTEENTH AMENDMENT'S GUARANTEE OF DUE PROCESS AND EQUAL PROTECTION OF THE LAWS.

If the Court accepts the reasoning of Director Miller that the plaintiffs' Title XIX claims are without merit, then it is appropriate that the Court should proceed to review the ruling of Judge Grady below that the federal and state abortion funding limitations are violative of the Fifth and Fourteenth Amendment to the United States Constitution. As defendant has already noted herein, the Fifth and Fourteenth Amendment questions do not materially differ. *Bolling* v. *Sharpe*, 347 U.S. 497 (1954) Both the state and federal statutes spring from the same legislative purpose—the protection of fetal life. Each statute's legislative history reflects the clash between those forces favoring and opposing the protection of this legitimate state interest in the context of medical assistance programs for the indigent. The concept of "medically necessary" abortions was debated in both the federal and state legislative forums and was rejected in both as being so amorphous as to permit abortion on demand. Finally, federal and state legislators who advocated passage of the legislation at issue were convinced that they were acting within the parameters of the Constitution in view of this Court's decision in *Maher* v. *Roe*, 432 U.S. 464 (1977), leaving such questions to the legislature. Director Miller submits that the question of governmental funding of all

"medically necessary" abortions is one best left to the legislature involving as it does a difficult policy choice over which reasonable men and women may, and do, differ. By superimposing its own notion of what is reasonable on the government, the District Court erred and its decision should be reversed.

Following the analytical method of the District Court, Director Miller shall first discuss whether P.A. 80-1091 "operates to the disadvantage of some suspect class or impinges upon a fundamental right explicitly or implicitly protected by the Constitution." *San Antonio School District* v. *Rodriguez*, 411 U.S. 1, 17 (1973).

Plaintiffs asserted below that the right involved is the right to an abortion as guaranteed in *Roe* v. *Wade*, 410 U.S. 113 (1973) and that the *Roe* right to an abortion implicates a right to state funding if the abortion is deemed "medically necessary." The threshold task, therefore, is to characterize the right asserted and the relationship of that right to the statutory provision under challenge.

A.

There Is No Fundamental Right To Abortion Or To A State Funded Abortion Expressly or Implicitly Protected by the Fourteenth Amendment.

The Fourteenth Amendment does not expressly provide a right to an abortion or to public funding for an abortion. In *Roe* v. *Wade*, 410 U.S. 113 (1973) this Court established the principle that a pregnant woman enjoys a qualified right of privacy under the Fourteenth Amendment's Due Process Clause sufficient to bar state infringement upon her right to choose between childbirth and abortion or upon her physician's right to provide that abortion free from the threat of criminal penalties:

> This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. 410 U.S. at 153.

It is equally well-established that a state may constitutionally decline to pay for "the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents."[32] *Maher* v. *Roe, supra,* 432 U.S. at 469 (1977).

The District Court found, and defendant contends here, that "the right recognized in *Roe* is not an affirmative right to an abortion, but is simply a right to make and effectuate the abortion decision." *Zbaraz* v. *Quern, supra,* 469 F.Supp. at 1217. The ruling in *Maher* v. *Roe* is controlling on the proper characterization of the *Roe* right and its relationship to state allocation of welfare benefits:

> [T]he right in *Roe* v. *Wade* can be understood only by considering both the woman's interest and the nature of the State's interference with it. *Roe* did not declare an unqualified "constitutional right to an abortion," as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy. It implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion, and to implement that judgment by the allocation of public funds.
>
> * * *

[32] *See also, Weinberger* v. *Salfi,* 422 U.S. 749, 771-772 (1975) ("... [A] non-contractual claim to receive funds from the public treasury enjoys no constitutionally protected status."); and *Lavine* v. *Milne,* 424 U.S. 577, 584 n.9 (1976) ("Welfare benefits are not a fundamental right, and neither the State nor the Federal Government is under any sort of constitutional obligation to guarantee minimum levels of support.").

> The indigency that may make it difficult—and in some cases, impossible—for some women to have abortions is neither created nor in any way affected by the Connecticut regulation.
>
> * * *
>
> There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy. 432 U.S. at 473-475.

The principle announced in *Maher* is as applicable to state laws withholding funding of "medically necessary" abortions as it is to limitations placed on funding of "elective" abortions. Either the *Roe* right is a sword with which its holder can attack any "state encouragement of an alternative activity consonant with legislative policy," *Id.* at 475, or it is a shield to protect its bearer "against state interference with certain aspects of an individual's personal 'privacy.'" *Id.* at 472. The Illinois statute "places no obstacles—absolute or otherwise—in the pregnant woman's path to [a medically necessary] abortion." *Id.* at 474. Plaintiffs here may encounter difficulty effectuating their decision to abort not because of P.A. 80-1091, but because of their indigency. *Zbaraz* v. *Quern, supra,* 469 F.Supp. at 1217. P.A. 80-1091 does not deny to pregnant indigent women seeking "medically necessary" abortions medical assistance benefits in general or medical assistance benefits for alternative modes of treating the complications of pregnancy where a physician is unable to reasonably certify an abortion as necessary to preserve the woman's life.

The *Maher* court acknowledged that "[t]he constitutionality of [a distinction between abortion and other procedures] will depend upon its degree and the justification for it," *Maher* v. *Roe, supra,* 432 U.S. at 473. Defendant Miller submits that the State's interest in fetal life in conjunction with its willingness to provide alternative care for the protection of maternal health justifies the distinction between "medically necessary" abortions and abortions "necessary for the preservation . . . of life."

Maher, therefore, is dispositive of the claim that implicit in the Fourteenth Amendment is a fundamental right to a state funded abortion within the context of a non-comprehensive medical assistance program for the indigent. Any doubts which may linger because this case, unlike *Maher*, involves some degree of medical need, should be resolved in favor of the State in light of the ruling in *Poelker* v. *Doe*, 432 U.S. 519 (1977). In *Poelker* this Court approved, over constitutional challenges, a policy and practice followed by two city owned hospitals in St. Louis, Missouri, that prohibited the performance of abortions in the hospitals unless "there was a threat of grave physiological injury or death to the mother." *Id.* at 520. In the lower court opinion, it is clear that this policy was interpreted to mean "to save the mother's life." *Doe* v. *Poelker*, 515 F.2d 541, 543 (8th Cir. 1975). The city's standard for medical necessity was identical to that contained in the Hyde Amendment and in P.A. 80-1091, and was far more restrictive than the "medically necessary" standard advocated by the plaintiffs. Yet the *Poelker* Court stated that "the constitutional question presented here is *identical in principle* with that presented by a State's refusal to provide benefits for abortion while providing them for childbirth." (emphasis added) *Id.* at 521.

Accordingly, neither the Hyde Amendment nor P.A. 80-1091, by restricting the funding of abortions to those "necessary for the preservation of . . . life," can be said to infringe upon any fundamental right of indigent women to secure public funding for all "medically necessary" abortions. This conclusion is inescapable from the principles central to the holdings in *Maher* and *Poelker*. Therefore, "[i]n the context of state funding of abortions, the right recognized in *Roe* v. *Wade* does not require the strict scrutiny that ordinarily would be triggered by the presence of a fundamental right within the scope of traditional Fourteenth Amendment analysis." *D*____ *R*____ v. *Mitchell*, 456 F. Supp. 609, 613 (D. Utah 1978), *appeal pending*, No. 78-1675 (10th Cir.); *accord*, *Zbaraz* v. *Quern*, *supra*, 469 F.Supp. at 1217.

As plaintiffs' complaint includes a claim that indigent women and their Medicaid physicians have a due process right to a state funded "medically necessary" abortion, it is appropriate to discuss the applicability of the Due Process Clause to the issues involved.

B.

The *Roe* v. *Wade* Right to Privacy May Not Be Transmuted On Substantive Due Process Grounds Into A Right To Public Funds For Abortions.

While *Roe* v. *Wade* may be seen as authorizing a limited resurrection of discarded notions of substantive due process characterized by decisions such as *Lochner* v. *New York*, 198 U.S. 45 (1905), such analysis is appropriate, if at all, only in instances of a "complete abridgment of a constitutional freedom." *Roe* v. *Wade*, *supra*, 410 U.S. at 170 (Stewart, J. concurring). Criminal abortion laws meet this test because of the extreme and compulsive nature of the state action involved. Generally, however, in a non-criminal setting and particularly in the setting of social welfare and economic legislation, due process analysis is avoided by the Court since it is tantamount to a judicial arrogation of legislative power.[33] In *Ferguson* v. *Skrupa*, 372 U.S. 726, 731 (1963), the Court referred to "our abandonment of the use of the 'vague contours' of the Due Process Clause to nullify laws which a majority of the Court believed to be economically unwise . . . We refuse to sit as a 'super-legislature' to weigh the wisdom of legislation."

It is precisely a weighing of the wisdom of P.A. 80-1091 which a due process claim invites. The Court, sitting as a "super-legislature," would weigh the woman's interest in her health, the physician's interest in professional discretion, the

[33] See, R. BERGER, GOVERNMENT BY JUDICIARY 249-282 (1977)

state's interest in fetal life, and the economics of abortion versus childbirth. The plaintiffs would urge the Court, sitting as a legislature, to determine that the state's interest in fetal life is outweighed by the women's concern for her health and the physician's willingness to abandon one of his two patients in the name of "medical necessity," and that the economics of the situation favor funding of abortions since that choice is less costly than paying for the expenses of childbirth. Then, presumably, based upon its own notions of what is wise policy, the Court would decide whether or not to fund all "medically necessary" abortions. It is respectfully submitted that such an approach is ill-conceived under the circumstances of this case and prior decisions of this Court.

Defendant Miller submits that the *Maher* court has limited the applicability of the doctrine of substantive due process to instances of "governmental intrusion, physical coercion and criminal prohibition of . . . [and] state interference with certain aspects of an individual personal 'privacy'." 432 U.S. at 471-472. The issue in this case as in *Maher* is not suitable for due process analysis since none of the indicia noted above are present. This is a case involving allocation of state funds in a manner deemed by the Illinois legislature to protect a legitimate state interest in fetal life without thereby compromising the State's interest in maternal health. The plaintiffs' due process right to privacy is no more or less affected by the legislation here than the *Maher* plaintiffs' rights were affected by the Connecticut regulation at issue there.

Moreover, when a woman asks the state to finance her abortion, her decision to have an abortion is no longer a private matter between her and her physician. When a woman and her physician assert a right to public funds, the constitutional focus switches from the individual's need for protection against undue state interference to a democratic society's need for collective judgments reflecting the policies and values of the community as a whole. The responsibility for this latter function has been committed in our system of government to the legislature.

The Court in *Maher* v. *Roe* recognized that the constitutional focus may vary depending upon the nature of the state action. The privacy right in *Roe* v. *Wade* "implies no limitation on the authority of the State to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds." *Maher* v. *Roe*, *supra*, 432 U.S. 473-474. Substantive due process is no limit on the state's fiscal autonomy to choose how to spend its tax dollars, even where the choice will require a greater rather than a lesser expenditure of public funds. The shortcomings of a substantive due process approach were expressly adverted to in *Maher*:

> Our conclusion that the Connecticut regulation is constitutional is not based on a weighing of its wisdom or social desirability, for this Court does not strike down state laws "because they may be unwise, improvident, or out of harmony with a particular school of thought." *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 488, 75 S.Ct. 461, 464, 99 L.Ed. 563 (1955), quoted in *Dandridge* v. *Williams*, *supra*, 397 U.S. at 484, 90 S.Ct. at 1161. Indeed, when an issue involves policy choices as sensitive as those implicated by public funding of nontherapeutic abortions, the appropriate forum for their resolution in a democracy is the legislature. We should not forget that "legislatures are ultimate guardians of the liberties and welfare of the people in quite as great a degree as the courts." 432 U.S. at 479-480 (citation omitted).

While some individuals may reasonably believe that the policy choice of the Illinois General Assembly to restrict abortion funding is harsh and unwise, or as the District Court felt, "cruel," 469 F.Supp. at 1221, this alone is insufficient justification to usurp the rightful exercise of the legislative function from the legislature in the absence of a complete abridgment of constitutional freedom. Director Miller submits that the Court should defer to the collective "wisdom" of the community as expressed through its elected representatives in appraising P.A. 80-1091. The right to privacy should not be judicially transmuted on substantive due process grounds into a right to public funds for a "medically necessary" abortion.

C.

No Constitutional Rights Of Treating Physicians Are Infringed By A Policy Decision To Limit Abortion Funding To Life-Preserving Situations.

Unlike the statutes in *Roe* v. *Wade*, 410 U.S. 113 (1973) and *Doe* v. *Bolton*, 410 U.S. 179 (1973), P.A. 80-1091 does not intervene or intrude upon, "the right of the physician to administer medical treatment according to his medical judgment", *Roe* v. *Wade*, 410 U.S. at 165, or criminalize the physician's conduct should he perform an abortion not covered by the statute. The State's determination that it will not pay for certain "medically necessary" abortions does not amount to unconstitutional coercion forcing the physician to otherwise alter his professional judgment or to obstruct his administration of medical treatment based upon that judgment.

Participation by physicians in the Medicaid program is wholly voluntary. The impact of P.A. 80-1091 is solely to condition the terms upon which the physician may be reimbursed should he decide to participate in that program. Congress and the states leave that decision solely up to each practitioner. Non-payment of "medically necessary" abortions falling outside the scope of P.A. 80-1091 is not the only limitation which a doctor may experience when he chooses to leave the private sector for the public. The federal government under Title XVIII (Medicare) and state governments under Title XIX (Medicaid) have great latitude in setting the amount of reimbursement for covered procedures and deciding which procedures are covered in the first instance. *Beal* v. *Doe*, 432 U.S. 438 (1977).

As an example of constitutionally permissible regulation of the medical profession, the Court is directed to the well-reasoned opinion of the court in *Association of American Physicians & Surgeons* v. *Weinberger*, 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd*, 423 U.S. 975 (1975). Plaintiff-physicians

challenged the enforcement of the "Professional Standards Review Law", 42 U.S.C. § 1320c *et seq.*, legislation designed to regulate physician abuses in the Medicare and Medicaid programs. The act was intended by Congress to prevent unnecessary hospitalization and unnecessary surgery. Among the constitutional claims pressed by the doctors was that the statute was unconstitutionally "arbitrary and overbroad and interferes with the plaintiffs' right to practice medicine", 395 F. Supp. at 131.

The Court disagreed, stating, "The statute, however, does not bar physicians from practicing their profession but only 'provides standards for the dispensation of federal funds.' " 395 F.Supp. at 132. "The 'Professional Standards Review' Law does not prohibit a physician from performing any surgical operations he deems necessary in the exercise of professional skill and judgment. It merely provides that if a practitioner wishes to be compensated for his services by the federal government, he is required to comply with certain guidelines and procedures enumerated in the statute." *Id.* at 134.

The physicians also alleged that the act unconstitutionally interfered with the physician-patient relationship by having a chilling effect on the practice of medicine to the detriment of the patient. Again, the Court disagreed since the statute expressly set forth reasonable and flexible standards for patient care. 395 F.Supp. at 134-135. Finally, the Court rejected the claim that the law violated the physician's privacy rights as articulated in *Roe* v. *Wade* since the government was deemed to have a significant "interest in maintaining proper health care in an economical manner." 395 F.Supp. at 136. *Cf.*, *American Association of Councils of Medical Staffs of Private Hospitals, Inc.*, v. *Mathews*, 421 F.Supp. 848 (E.D. La. 1976), *vacated on other grounds*, 575 F.2d 1367 (5th Cir. 1978); *Lang* v. *Berger*, 427 F.Supp. 204 (S.D.N.Y. 1977).

Illinois does not directly intrude upon the practice of medicine, the physician-patient relationship, or the physician's right to privacy when it limits public funding for abortions to

those "necessary for the preservation of . . . life." The standard for funding of abortions under P.A. 80-1091 is reasonable given the state's interest in fetal life and the availability of alternative modes of treating the complications of pregnancy. The Illinois statute leaves the physician ample room to exercise his professional judgment should he elect to participate in the Medicaid program. The physician's hands are not tied. His freedom to practice medicine is not abridged since he is free to provide a "medically necessary" abortion to a patient without fear of criminal sanctions or other coercive measures.

The State does not monopolize the delivery of health care. However, within the health care system it does administer, the State has the authority to decide what will be a covered, reimbursable service, and this power does not amount to state interference with the practice of medicine. The physician remains free to treat his patients, whether in the private or public sector, and free to perform any abortion he deems appropriate or "medically necessary." The State is simply refusing to pay for abortions not necessary for the preservation of the mother's life by its enforcement of P.A. 80-1091.

D.

P.A. 80-1091 Creates No Suspect Classification Based On Wealth.

The limitations of P.A. 80-1091 do not involve invidious discrimination against a suspect class even though the denial of public funding for "medically necessary" abortions may be said to create a "wealth classification." *San Antonio School District* v. *Rodriguez*, 411 U.S. 1 (1973). The Constitution does *not* require absolute equality. *Douglas* v. *California*, 372 U.S. 353, 357 (1963). Most legislation classifies people in one way or another or discriminates between classes of people. However, it is only invidious discrimination which violates the Constitution.

Invidious discrimination has been defined as legislation that singles out certain traditionally deprived minorities for special treatment, and that works to their disadvantage. *San Antonio School District, supra,* 411 U.S. at 28. Suspect classifications include:[34] race (*Korematsu* v. *United States*, 323 U.S. 214 (1944)); alienage (*Graham* v. *Richardson*, 403 U.S. 365 (1971)); and national origin (*Hernandez* v. *Texas*, 347 U.S. 475 (1954)).

The essence of equal protection simply stated is that all individuals are entitled to a certain equality of treatment at the hands of government. The government is not constitutionally obligated to eliminate life's inequities. On the other hand, the state may not confer substantial benefits on one class of persons and simultaneously deprive another class of persons of the same benefits without justification.

Under the foregoing standards, the legislation in question does not involve invidious discrimination on the basis of wealth. The State has not conferred any benefit upon wealthy women that it similarly denies to indigent women. Rather, all women who become pregnant—rich or poor—are treated in an identical manner with respect to the availability of State funds for abortions. The State has merely chosen not to fund a particular *class of abortions* regardless of whether the woman involved be rich, poor, black, white, Spanish-speaking, or English-speaking. The fact that the more affluent woman can nevertheless obtain an abortion is not invidious discrimination. The same holds true for any benefit the State chooses not to provide. The more affluent will always be in a better position to escape the adverse consequences of such State decisions.

---

[34] The *Rodriguez* court listed some of the traditional indicia of a suspect class: "a class . . . saddled with such disabilities, or subjected to such a history of purposeful unequal treatment or relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." 411 U.S. at 28.

As stated by Justice Harlan dissenting in *Douglas* v. *California*, 372 U.S. 353, 361-362 (1963):

> The States, of course, are prohibited by the Equal Protection Clause from discriminating between 'rich' and 'poor' *as such* in the formulation and application of their laws. But it is a far different thing to suggest that this provision prevents the State from adopting a law of general applicability that may affect the poor more harshly than it does the rich, or, on the other hand, from making some effort to redress economic imbalances while not eliminating them entirely.
>
> Every financial exaction which the State imposes on a uniform basis is more easily satisfied by the well-to-do than by the indigent. Yet I take it that no one would dispute the constitutional power of the State to levy a uniform sales tax, to charge tuition at a state university, to fix rates for the purchase of water from a municipal corporation, to impose a standard fine for criminal violations, or to establish minimum bail for various categories of offenses. Nor could it be contended that the State may not classify as crimes acts which the poor are more likely to commit than are the rich. And surely, there would be no basis for attacking a state law which provided benefits for the needy simply because those benefits fell short of the goods or services that others could purchase for themselves.
>
> Laws such as these do not deny equal protection to the less fortunate for one essential reason: the Equal Protection Clause does not impose on the States "an affirmative duty to lift the handicaps flowing from differences in economic circumstances." To so construe it would be to read into the Constitution a philosophy of leveling that would be foreign to many of our basic concepts of the proper relations between government and society. The State may have a moral obligation to eliminate the evils of poverty, but it is not required by the Equal Protection Clause to give to some whatever others can afford.

The holding of the Court in *Douglas* and *Boddie* v. *Connecticut*, 401 U.S. 371 (1971), that state payment of court

related fees for indigents may be constitutionally mandated is an exception to the general rule that legislative classification related to ability to pay are not suspect. In the absence of a fundamental right or government monopoly of a service, these exceptions will not apply. *Maher* v. *Roe*, *supra*, 432 U.S. at 471 n. 6. There is no fundamental right to Medicaid abortion, and Illinois does not have a monopoly on the means for terminating a pregnancy or providing health care.

The indigent woman is as free to seek and procure an abortion as her more affluent counterpart. The fact that her economic circumstances make that task a far more difficult proposition is not the State's doing. The State is not the cause (at least in a legal sense) of her plight. The decision of the State not to rescue her may seem to be a harsh decision, but it is one which is constitutionally permissible.

If a woman is poor and chooses to have a child, the State will pay for the expenses of childbirth. If a woman is poor and elects to have a "medically necessary" abortion, the State will not pay unless it falls within the standard of P.A. 80-1091. For purposes of equal protection analysis, the salient point is that the disparate treatment is not invidious. The distinction here is drawn between women of similar economic circumstance. The State has chosen to provide some benefits to the poor and not to provide others.

These principles have been ratified by the Supreme Court in *Maher* v. *Roe:*

> In a sense, every denial of welfare to an indigent creates a wealth classification as compared to nonindigents who are unable to pay for the desired goods or services. But this Court has never held that financial need alone identifies a suspect class for purposes of equal protection. 432 U.S. at 471.

It follows that the state's classification scheme singling out abortions necessary for the preservation of life for funding creates no suspect classification of individuals based upon wealth.

E.

Illinois Does Not Penalize The Decision to Abort By Funding Only "Life-Preserving" Abortions.

The "penalty analysis" implicit in application of *Shapiro* v. *Thompson*, 394 U.S. 618 (1969) and *Memorial Hospital* v. *Maricopa County*, 415 U.S. 250 (1974) to the facts in *Maher* was specifically rejected by the *Maher* Court in the context of abortion funding.

> If Connecticut denied general welfare benefits to all women who had obtained abortions and who were otherwise entitled to the benefits, we would have a close analogy to the facts in *Shapiro*, and strict scrutiny might be appropriate under either the penalty analysis or the analysis we have applied in our previous abortion decisions. But the claim here is that the State "penalizes" the woman's decision to have an abortion by refusing to pay for it. *Shapiro* and *Maricopa County* did not hold that States would penalize the right to travel interstate by refusing to pay the bus fares of the indigent travelers. 432 U.S. at 474 n.8.

Government does not infringe upon the indigent's right to travel by "refusing to pay the bus fare of indigent travelers" whether travel is deemed necessary to "well-being" or not. Similarly, government incurs no supernumerary obligation to finance abortion deemed "medically necessary" in view of its contrary interest in protection of potential human life.

Illinois does not deny medical assistance benefits to women seeking a "medically necessary" abortion since it funds alternative modes of treating the complications of pregnancy. The speculation that P.A. 80-1091 will result in "increased maternal morbidity and mortality" is insufficient to support a finding that the State "penalizes" the woman's decision to abort given the availability of alternative treatment. *See*, discussion in Part III, *supra*.

F.

P.A. 80-1091 Is A Rational Means Of Protecting Legitimate State Interests.

The District Court, agreeing generally with the contentions of defendant in sections A through C of Part VI of this brief, properly determined "that P.A. 80-1091 should not be subject to strict judicial scrutiny." *Zbaraz* v. *Quern*, 469 F.Supp. 1212, 1218. Following the lead of this Court in *Maher* it measured P.A. 80-1091 under the less stringent test of "rationality," in order to determine whether the withholding of funds for "medically necessary" abortions violated the constitution.[35] It then purported to identify the interests advanced by the defendants in support of the funding limitation. The first interest it identified was the state's interest in "fiscal frugality." The State, however, never asserted that it had an interest in "fiscal frugality." *See*, R. 102, Defendant Quern's Memorandum of Law on the Constitutional Questions. The interest which the State did assert was the right to allocate welfare funds according to its own policies, regardless of cost, in order to protect a legitimate state interest. In this brief, Director Miller has labeled this as an interest in "fiscal autonomy," which arises out of a legislative responsiveness to the ethical concerns of the people of the State as to the uses put to their tax dollars.

The District Court found that the Illinois policy could not be rationally related to any interest in "fiscal frugality" since abortion is less costly than childbirth. 469 F.Supp. at 1218. The Court then considered the State's interest in the protection

---

[35] The Court should not be misled by an inadvertent error on the part of the District Court, 469 F. Supp. at 1215 n.4, characterizing prior state regulations as incorporating a *Doe* v. *Bolton* definition of "therapeutic." The definition was part of a regulation imposed on the state agency by prior court rulings in this litigation. While the cover sheet of the regulations was dated January, 1976, the definitional page was inserted in 1978.

of the fetus through the encouragement of childbirth. *Id.* at 1219. While recognizing that this was a legitimate state interest under the Court's ruling in *Maher* and *Poelker*, the District Court purported to find a "crucial" distinction between the refusal to expend funds for "nontherapeutic" abortions and "medically necessary" abortions. Under the Court's view of the funding restriction "the mother may be subjected to considerable risk of severe medical problems, which may even result in her death," *id.*, by the failure of the State to fund all "medically necessary" abortions. This speculation as to medical risks was based wholly and uncritically upon the affidavits of certain physicians submitted by the plaintiffs in support of their motion for summary judgment. For a critique of those affidavits, see Part III, *supra*. The Court purported to make a finding of fact that "The effect of the [funding limitation] will be to increase substantially maternal morbidity and mortality among indigent pregnant women." *Id.* at 1220. This "fact" should have been weighed against the availability of alternative treatment (R.61, affidavit of Jasper Williams, M.D.) and the state's assertion that it did not second-guess the judgment of physicians regarding certification of an abortion as necessary for the preservation of life (R. 109, affidavit of Kenneth Wilson).

More significantly, the Court should have been hesitant to adopt a standard of "necessity" under which a physician would readily certify every other pregnant woman he treated as needing a "medically necessary" abortion (R.101, affidavit of Oren Richard Depp, III, M.D.).

Defendant submits therefore that the District Court erred in concluding that the State's legitimate interest in fetal life prior to viability was outweighed by the interest of indigent women for whom an abortion, in the opinion of their physician, is "medically necessary" as defined in the affidavits. The effect of the ruling is to overturn the holding in *Maher* v. *Roe* that a state need not fund nontherapeutic abortions for there is no practical difference between "medically necessary" abortions as defined by plaintiffs and elective abortion on demand.

The State's abortion funding statute is a rational means of protecting legitimate state interests. In sections A through C of Part VI of this brief Defendant Miller has demonstrated that the plaintiffs have no fundamental right to a publicly funded abortion where the physician determines that an abortion is "medically necessary" but not necessary for preservation of his patient's life. None of the traditional constitutional approaches which justify heightened judicial scrutiny are applicable to the case at bar. P.A. 80-1091 is not patently arbitrary or wholly lacking any rationale and it does not completely abridge a constitutional freedom. The act neither creates a suspect classification based on wealth, nor unconstitutionally penalizes the rights of pregnant indigent women in view of the availability of alternate modes of treating the complications of pregnancy. It establishes a policy of social welfare.

In *Dandridge* v. *Williams*, 397 U.S. 471, 486 (1970), this Court established the standard by which legislative classifications in the area of economics and social welfare are to be measured:

> In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some 'reasonable basis,' it does not offend the Constitution simply because the classification 'is not made with mathematical nicety or because in practice it results in some inequality . . .' A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it . . . It is a standard that is true to the principle that the Fourteenth Amendment gives the Federal Courts no power to impose upon the States their economic view of what constitutes wise economic policy or social policy. (citations omitted).

Applying this standard to the Connecticut regulation governing the funding of non-therapeutic abortions, the Court in *Maher* v. *Roe* found that the State had a constitutionally permissible interest in protecting the potential life of the fetus which exists

throughout pregnancy, 432 U.S. at 478, and that the "subsidizing of costs incident to childbirth is a rational means of encouraging childbirth." 432 U.S. at 479. In addition demographic concerns were recognized as legitimate. 432 U.S. at 478 n.ll.

The debates on P.A. 80-1091 indicate that the Illinois legislators advanced each of the above identified state interests in support of the legislation. In addition, the Illinois legislators asserted an interest in fiscal autonomy arising from the moral beliefs of their constituents that abortion on demand should not be supported by tax dollars. Illinois State Senator Lemke, the sponsor of P.A. 80-1091 stated this interest in the following manner:

> My people don't want abortions being performed with their money. If it costs them more to support these children after they're born, they will pay that money gladly as long as it is properly used. (App. 64).

The legislation at issue in this case rationally furthers these legitimate state interests. The restriction on public funds for abortion to those "necessary for the preservation of . . . life" is rational since it prevents the unnecessary termination of fetal life without harming maternal health. It is rational to distinguish abortions from other medical procedures since "other procedures do not involve the termination of potential human life." *Maher* v. *Roe, supra,* 432 U.S. at 480. By encouraging childbirth and discouraging unnecessary abortions the state is avoiding the use of state funds in a manner thought to be unethical by its citizens. It is rational for the state to take into consideration ethical reservations regarding abortion held by its citizens because the ethical issue involves the most compelling interest of the state: "the interest in maintaining that respect for the paramount sanctity of life which has always been at the center of western civilization." A. Cox, The Role of the Supreme Court in American Government, 53 (1974).

In conclusion, Illinois has several legitimate interests which are advanced by P.A. 80-1091 including the interest in encouraging normal childbirth which the *Maher* court held to exceed the minimum level of scrutiny necessary to survive an equal protection challenge. For this reason Defendant Miller asks that the principles formulated in *Maher* v. *Roe,* as applied in *Poelker* v. *Doe,* be extended to this case. The application of *Maher* and *Poelker* to this case, defendant submits, requires the reversal of the ruling below that P.A. 80-1091 violates the Fourteenth Amendment's guarantee of equal protection of the laws.

CONCLUSION

Director Miller asks the Court to clarify the nature of the state's obligation to provide abortion funding under Title XIX of the Social Security Act, as passed and as modified by the Hyde Amendment. The Court should examine the *Doe* v. *Bolton* concept of "medical necessity" and find that it has no applicability to the process by which a state determines what specific medical procedures a state will fund within the context of a non-comprehensive program of medical assistance for the needy. In this respect the Court should clarify the dictum in *Beal* v. *Doe* that a regulation proscribing "medically necessary" abortions might run afoul of the requirements of Title XIX.

Director Miller requests that the Court weighs the affidavits of the physicians submitted in this case against the state's willingness to fund alternative modes of treatment for the complications of pregnancy and its reasonable interpretation of a "life-preservation" standard. Defendant submits that the affidavits do not support the conclusion that enforcement of P.A. 80-1091 will necessarily result in "increased maternal morbidity and mortality," and that the plaintiffs' concept of "medical necessity" is tantamount to abortion on demand.

The Court should reverse the ruling of the District Court holding Illinois' abortion funding limitation statute unconstitutional and reaffirm, in the context of this litigation, the principles underlying the ruling in *Maher* v. *Roe* and *Poelker* v. *Doe*. Those decisions clearly establish the following principles:

1. The fundamental right to privacy established in *Roe* v. *Wade* is a non-interference right, not an unqualified "constitutional right to an abortion" and certainly not a right to a state funded abortion on demand.

2. The limitation of state welfare funds for the payment of abortions does not impinge upon a woman's right to privacy.

3. A classification based upon indigency is not a "suspect classification."

4. The refusal to fund the exercise of a constitutionally protected right does not "penalize" the holder of that right.

5. The State has a "strong interest in potential human life" and in "protection of the fetus."

6. The encouragement of childbirth through governmental subsidy of costs incident to childbirth is a rational and constitutionally permissible means of protecting the State's "strong and legitimate interest in encouraging natural childbirth."

7. A city policy prohibiting the performance of abortions except where there is "a threat of grave physiological injury or death" is constitutionally indistinguishable from a state policy restricting Medicaid benefits for non-therapeutic abortions while providing them for childbirth.

In the alternative, should this Court uphold the ruling of the District Court, Director Miller requests that the District Court be directed to order the United States to reimburse the State of Illinois for all Title XIX abortions which it will be required to fund under the Court's ruling.

Respectfully Submitted,

WILLIAM J. SCOTT,
Attorney General of Illinois
Attorney for Appellant.

WILLIAM A. WENZEL, III,
JAMES C. O'CONNELL,
ELLEN P. BREWIN,
Special Assistant Attorneys General
130 North Franklin Street, Suite 300
Chicago, Illinois 60606
(312) 793-2380
Of Counsel

ADDENDUM

PUBLIC ACT 80-1091 (eff. Nov. 17, 1977)

AN ACT to amend Sections 5-5, 6-1 and 7-1 of "The Illinois Public Aid Code", approved April 11, 1967, as amended.

Be it enacted by the People of the State of Illinois represented in the General Assembly:

Section 1. Sections 5-5, 6-1 and 7-1 of "The Illinois Public Aid Code", approved April 11, 1967, as amended, are amended, the amended Sections to read as follows:

(Ch. 23, par. 5-5)

Sec. 5-5. Medical services.) The Illinois Department, by rule, shall determine the quantity and quality of the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services; (14) transportation and such other expenses as may be necessary; (15) medical treatment of rape victims for injuries sustained as a result of the rape, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the rape; (16) any other medical care, and any other type of remedial

care recognized under the laws of this State, *but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.* The preceding terms include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

* * * * *

The rules and regulations of the Illinois Department shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for abortions, or induced miscarriages or premature births. This statement shall indicate what procedures were used in providing such medical services.

* * * * *

(Ch. 23, par. 6-1)

Sec. 6-1. Eligibility requirements.) Financial aid in meeting basic maintenance requirements for a livelihood compatible with health and well-being, plus any necessary treatment, care and supplies required because of illness or disability, shall be given under this Article to or in behalf of persons who meet the eligibility conditions of Sections 6-1.1 through 6-1.6. *Nothing in this Article shall be construed to permit the granting of financial aid where the purpose of such aid is to obtain an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.*

Until August 1, 1969, children who require care outside their own homes, where no other sources of funds or insufficient funds are available to provide the necessary care, are included among persons eligible for aid under this Article. After July 31, 1969, the Department of Children and Family Services shall have the responsibility of providing child welfare services to such children, as provided in Section 5 of "An Act creating the Department of Children and Family Services, codifying its powers and duties, and repealing certain Acts and Sections herein named", approved June 4, 1963, as amended.

(Ch. 23, par. 7-1)

Section. 7-1. Eligibility requirements.) Aid in meeting the costs of necessary medical, dental, hospital, boarding or nursing care, or burial shall be given under this Article to or in behalf of any person who meets the eligibility conditions of Sections 7-1.1 through 7-1.3, *except where such aid is for the purpose of obtaining an abortion, induced miscarriage or induced premature birth unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.*

(Emphasis added)

DEPARTMENTS OF LABOR, AND HEALTH, EDUCATION, AND WELFARE, APPROPRIATION ACT, 1977 PUBLIC LAW 94-439, 90 STAT. 1418, 1434 (Sept. 30, 1976)

SEC. 209. None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.

DEPARTMENTS OF LABOR, AND HEALTH, EDUCATION, AND WELFARE, AND RELATED AGENCIES, APPROPRIATION ACT, 1978—CONTINUING APPROPRIATIONS—PUBLIC LAW 95-205, 91 STAT. 1460 (Dec. 9, 1977)

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated out of any money in the Treasury not otherwise appropriated, and out of applicable corporate or other revenues, receipts, and funds, for the several departments, agencies, corporations, and other organizational units of the Government for the fiscal year 1978, namely:

SEC. 101. Such amounts as may be necessary for continuing projects or activities which were conducted in the fiscal year 1977, and for which appropriations, funds, or other authority would be available in the District of Columbia Appropriations Act, 1978 (H.R. 9005) as passed the House of Representatives or the Senate, but at a rate of operations not in excess of the current rate: *Provided,* That the Advisory Neighborhood Commissions shall be continued at an annual rate of not to exceed $500,000: *Provided further,* That the rate of operations for the Disaster Loan Fund of the Small Business Administration contained in said Act shall be the rate as passed the Senate.

Such amounts as may be necessary for projects or activities provided for in the Departments of Labor, and Health, Education, and Welfare, and Related Agencies Appropriation Act, 1978 (H.R. 7555), at a rate of operations, and to the extent and in the manner, provided for in such Act, notwithstanding the provisions of Sec. 106 of this joint resolution: *Provided,* That none of the funds provided for in this paragraph shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the termination of an ectopic pregnancy.

The Secretary shall promptly issue regulations and establish procedures to ensure that the provisions of this section are rigorously enforced.

DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS ACT, 1979 PUBLIC LAW 95-480, 92 STAT. 1567, 1586 (Oct. 18, 1978)

SEC. 210. None of the funds provided for in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service;

or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the termination of an ectopic pregnancy.

JOINT RESOLUTION [H.J. RES. 440] PUBLIC LAW 96-123, 93 STAT. 923, 926 (Nov. 20, 1979)

SEC. 109. Notwithstanding any other provision of this joint resolution except section 102, none of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service;

Nor are payments prohibited for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures necessary for the termination of an ectopic pregnancy.

Chapter 100

General Policy and Procedure

100. ILLINOIS MEDICAL ASSISTANCE PROGRAM

101. *Authority*

The Illinois Medical Assistance Program is the Federal-State public assistance program which implements Title XIX of the Social Security Act (Medicaid). It is administered by the Department of Public Aid under Article V of the Illinois Public Aid Code. The Department has statutory responsibility for the formulation of policy in conformance with Federal and State requirements.

102. *Objective*

The objective of the Medical Assistance Program is to enable eligible recipients to obtain essential medical care and services necessary to preserve health, alleviate sickness, and correct handicapping conditions. Such care and services are provided when they are not either available without charge or covered by health insurance or other third party resource.

Essential care and services are those which are generally recognized as standard medical services required because of disease, disability, infirmity or impairment. The Department reserves the right to determine the necessity of providing medical care in individual situations, with the determination based on recommendations of technical and professional staff, and advisory committees.

Both fiscal considerations and good administrative practice require the imposition of certain limitations and controls on the kind and amount of medical care and services covered in the Medical Assistance Program. Careful review of the subsequent material will enable the medical services provider to identify specific Program coverage and limitations.

110. PROVIDER PARTICIPATION

To receive payment for medical care, services, or supplies provided to Public Aid recipients, a provider must be approved for participation by the Department. To be considered for participation, a provider is to contact Illinois Department of Public Aid, Post Office Box 4034, Springfield, Illinois 62708. (See General Appendix 8 for appropriate telephone number.)

111. *Requirements*

Requirements for providers approved for participation include but are not limited to the following:

1) Notification to the Department, in writing, immediately whenever there is a change in any of the information which the provider previously submitted to the Department.

2) Allowance of recipients a freedom of choice in seeking medical care from any institution, agency, pharmacy, or person who is a participant in the Medical Assistance Program.

3) Allowance of recipients a freedom to reject medical care and treatment.

4) Provision of services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the grounds of race, color, or national origin and with the Rehabilitation Act of 1973 and Part 84 of the Federal Regulations which prohibit discrimination on basis of handicap.

5) Provision of services and supplies to recipients without discrimination on the basis of religious belief, political affiliation, or sex.

6) Provision of services and supplies to recipients in the same quality and mode of delivery as are provided to the general public.

7) Making of charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

8) Acceptance as payment in full the amounts established by the Department.

9) Acceptance of assignment of Medicare benefits for Public Aid recipients eligible for such benefits.

10) Use of Department designated billing forms for submittal of charges.

11) Maintenance and retention of business and professional records sufficient to fully and accurately document the nature, scope and details of the health care provided. (Refer to Section II for specific record content.)

Such records must be retained for a period of not less than three years from date of service or as provided by applicable State laws, whichever period is longer; except that, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

12) Furnishing to the Department, in the form and manner requested, pertinent information regarding services for which charges are made.

13) Disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to recipients of Public Aid.

14) Holding confidential, and using for authorized program purposes only, all Medical Assistance information regarding recipients.

15) The provider shall comply with the requirements of applicable Federal and State laws and shall not engage in practices prohibited by applicable Federal and State law.

112. *Termination of Provider Participation*

A participating provider may terminate his participation in the Medical Assistance Program at any time. Written notification of voluntary termination is to be made to the Illinois Department of Public Aid, Post Office Box 4034, Springfield, Illinois 62708.

The Department may administratively terminate a provider from participation upon written notification. Such action precludes further payment by the Department for services provided recipients subsequent to receipt of the Department notice of intent to terminate. (See General Appendix 7A, Rules for Department Actions Against Medical Vendors, for actions on which termination may be based.)

The Department notification to the provider of intent to terminate his participation will include a Statement of Grounds and a statement of the right of the provider to request a hearing prior to termination.

During the hearing, payments on pending and subsequently received bills is withheld for up to 120 days (or longer if delay is caused by the provider or mutually agreed to by the Department and the provider).

120. RELATIONSHIP TO OTHER PROGRAMS

Payment can be made through the Medical Assistance Program only after all other known resources for payment, both private and government, have been explored and exhausted.

121. *Other Agency Resources*

State agencies other than the Department of Public Aid have responsibility for coordinating the provision of selected medical services under specified conditions. When a Public Aid recipient is eligible for the services of other agencies, such resources must be used first. Such agencies include, but are not limited to, those whose programs are described below.

University of Illinois Division of Services for Crippled Children

The Division of Services for Crippled Children provides for care and treatment of children from birth to age 21 who have crippling or potentially crippling conditions. Children who have one of the following conditions are to be referred to that Agency for evaluation, either directly by the provider or through the local Public Aid office.

1. Orthopedic handicaps
2. Neurological handicaps
3. Cardiac handicaps
4. Body deformities which are amenable to plastic surgery
5. Speech defects associated with congenital or acquired brain, oral, or pharyngeal defects
6. Hearing loss or deafness
7. Rheumatoid arthritis
8. Tracheo-esophageal fistula
9. Cystic fibrosis
10. Phenylketonurial

Chapter A-200

Physicians' Services

For consideration to be given by the Department to payment for physicians' services, such services must be provided in full compliance with both the general provisions contained in Chapter 100 and the policy and procedures set forth herein.

A-200. BASIC PROVISIONS

A-201. *Physicians Participation*

A Doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a valid Illinois (or State of practice) license to practice medicine in all its branches, is eligible for approval to participate in the Medical Assistance Program; however, special policy applies to the participation of physicians who receive salaries from hospitals and/or medical schools.

.1 Interns are not approved as participating physicians as the cost of their services is included in the hospital's reimbursable costs.

.2 Residents generally are excluded from participation on the same basis as interns; except that where, by terms of their contract with the hospital, they are permitted to and do bill private patients and collect and retain the payments received for their services, participation may be approved.

.3 Hospital based specialists who are salaried, with the cost of their services included in the hospital reimbursable costs, are not approved for participation. Participation may be approved for those physicians whose contractual arrangement with the hospital provides for them to make their own charges for professional services and they do, in fact, bill private patients and collect and retain payments made.

.4 Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools may be approved for participation in the provision of direct patient services if they maintain a private practice and bill, collect from, and retain payments made by patients.

.5 Teaching physicians who provide direct patient care may be approved for participation provided that salaries paid by hospitals or other institutions do not include a component for treatment services.

* * *

A-203. *Covered Services*

A covered service is a service for which payment can be made by the Department. Covered are those reasonably necessary medical and remedial services which are recognized as standard medical care required because of illness, disability, infirmity, or impairment, and which are necessary for immediate health and well-being.

Any question a physician may have about coverage of a particular service is to be directed to the Department prior to provision of the service.

A-204. *Services Not Covered*

Services for which medical necessity is not clearly established are not covered in the Medical Assistance Program. Additionally, the following services are specifically excluded from coverage and payment cannot be made by the Department for the provision of these services.

a. Preventive services, other than those 1) included in the Medichek Program for children through age 20 or; 2) required for school attendance.
b. Routine physical examinations.
c. Examinations required for the determination of disability or incapacity or for entrance into educational or vocational programs (Local Public

Aid offices may request that such examinations be provided with payment authorized from non-medical funds. Physicians are to follow specific billing instructions given when such a request is made.)

d. Abortion except where necessary for the preservation of the life of the expectant mother and "therapeutic" abortions, "therapeutic" being defined as follows: "medically necessary or medically indicated according to the professional medical judgment of a licensed physician in Illinois, exercised in light of all factors affecting a woman's health."

e. Experimental medical or surgical services.

f. Acupuncture.

g. Investigational and research oriented procedures.

h. Artificial insemination.

i. Transsexual surgery.

j. Services prohibited by Illinois or Federal statute.

k. Services provided in Federal or State institutions.

l. Medical care provided by mail or telephone.

m. Unkept Appointements.

n. Autopsy examinations.

o. Preparations of routine records, forms and reports.

p. Subsequent treatment for veneral disease, when such services are available through State and/or local health agencies.

q Vistis with persons other than a recipient, such as family members or group care facility staff.

r. Diagnostic and/or therapeutic procedures related to primary infertility/sterility.

s. Cosmetic procedures, medical or surgical, where projected results do not relieve a physical or functional handicap.

A-205 *Service Limitations and Requirements*

The following services are covered in the Medical Assistance Program only when provided in accordance with the limitations and requirements specified.

A-205.1 Termination of Pregnancy—Induced Abortions

An induced abortion is a covered service:

(a) when it is performed prior to fetal viability, and a licensed physician in Illinois certifies in writing that the procedure is "medically necessary". A "medically necessary" abortion is an abortion which is necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in light of all factors relevant to her health. "Fetal viability" means the point during pregnancy at which, in the professional judgment of a licensed physician in Illinois, a fetus is potentially able to live outside the mother's womb, albeit with artificial aid, such that there is a potentiality for meaningful life, not merely momentary survival; OR,

(b) regardless of whether the abortion is performed prior to or after fetal viability, if it is certified in writing:

(i) by a licensed physician in Illinois, that (s)he has determined that the life of the mother would be endangered if the fetus were carried to term; OR,

(ii) by two licensed physicians in Illinois that they have determined that severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term; OR,

(iii) that the abortion is necessary for a victim of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or

public health service. (A pregnant woman under 18 is considered to have been the victim of rape, even if she was not forced to have sexual relations.) Note that the required report must be made within 60 days of the incident and must show the name and address of the victim and the date of the incident. It also must show the name, address and signature of the person making the report and the date of the report.

To receive payment for abortions as described in the preceding paragraphs, Form DPA 1862, Abortion Certification (Revised 5-79) must be completed and submitted with the billing statement. (See Appendix A-7).

As appropriate, copies of the Abortion Certification are to be made available to the hospital to submit with the Form DPA 117, Inpatient Invoice, and to the anasthesiologist to submit with the Form DPA 132, Physician's Statement of Services Rendered.

A supply of Forms DPA 1862 may be obtained by writing Illinois Department of Public Aid, Post Office Box 4034, Springfield, Illinois 62708.

PROCEDURE: When billing for an induced abortion covered by the program under paragraph (a) above, the physician is to use the appropriate procedure code from the *Current Procedural Terminology, Second Edition.* Abortions billed as meeting the criteria in paragraph (b) above should be coded according to the following codes, identifying the reason why the procedure was necessary.

Code 59730—*Mother's Life Endangered*

The professional judgment of the physician that the life of the mother would be endangered if the fetus were carried to term.

Code 59740—*Severe and Long Lasting Health Damage*

The professional judgment of two physicians that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term.

Code 59750—*Rape or Incest*

One all-inclusive charge is to be made for the total service provided.

A-205.2 Sterilization

Therapeutic sterilization is a covered service. A therapeutic sterilization is defined as one which either is a necessary part of the treatment of an existing illness or is medically indicated as an accompaniment of an operation on the female genitourinary tract. For purposes of this definition mental incapacity is not considered an illness or injury.

PROCEDURE: Billing statements for all therapeutic procedures which result in sterilization must indicate clearly under "Diagnosis" the therapeutic nature of the procedure. Bills on which the therapeutic intent is unclear will be returned.

Non-therapeutic sterilization is a covered service only for recipients age 21 or older, and only when mutually agreed upon by the recipient and the physician. Before proceeding to perform a sterilization, the physician must obtain the written informed consent of the recipient and advise him of his right to withdraw consent any time prior to the operation, which may be performed no sooner than 72 hours following the giving of the informed consent.

Consent must be obtained in a language understandable to the individual upon whom the procedure is to be performed.

PROCEDURE: When a recipient requests a non-therapeutic sterilization, the physician is to explain thoroughly the content of Form DPA 2189, Consent for Non-Therapeutic Sterilization (see Appendix A-6), to the recipient in the presence of an auditor-witness, designated by the recipient. This informed consent form must be signed by the physician who is to perform the procedure, the individual who is to be sterilized and the auditor-witness.

The signed Form DPA 2189 is to be attached to the physician's billing statement when charges are made for a non-therapeutic sterilization.

When a non-therapeutic sterilization is performed in a hospital by a salaried hospital staff physician, the signed Form DPA 2189 is to be attached to the hospital billing statement.

A-205.3 End Stage Renal Disease Treatment

End stage renal disease treatment—chronic hemodialysis and kidney transplantation— is a covered service only for those recipients who have been determined medically eligible for such treatment by the Illinois Department of Public Health. For recipient-patients who require end stage renal disease treatment, the physician is to submit a medical report and treatment recommendation to:

Illinois Department of Public Health
Bureau of Personal and Community Health
Renal Dialysis Program
535 West Jefferson Street
Springfield, Illinois 62761

If determined medically eligible for treatment, the recipient will be referred to a Medicare certified facility for end stage renal disease treatment. Professional staff in the facility will have responsibility for management of the treatment program and will determine the appropriate type of services needed at any time, i.e., inpatient hospitalization, outpatient or home dialysis, or kidney transplantation.

Facilities are responsible for submitting charges for outpatient and home dialysis services. Such charges are all inclusive and no additional professional charges are to be made.

Physicians may submit charges to the Department for peritoneal dialysis and other services provided during a period of inpatient hospitalization. The amount paid for shunt insertions cannot exceed the Medicare approved charge.

A-205.4 By-Pass Surgery for Morbid Obesity

This type of surgery is a covered service only with prior approval of the Department. Approval is given only in those cases in which obesity is determined to be exogenous in nature with the recipient having had the benefit of other forms of therapy (dietary, etc.) with no success, and after procedures have been performed to rule out endocrine disorders. The responsibility for the determination of cases in which these criteria are met rests with the Department.

PROCEDURE: A physician must request prior approval to do by-pass surgery from:

Illinois Department of Public Aid
Post Office Box 4035
Springfield, Illinois 62708

The physician will be advised to the specific information required for consideration to be given to his request.

If charges are submitted without prior approval consideration will not be given to payment.

A-205.5 Psychiatric Services

Treatment

Psychiatric treatment services are not covered services for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97).

The psychiatric treatment program of the Department is coordinated by the Department of Mental Health and Developmental Disabilities (DMHDD). A physician who desires to provide psychiatric care and services to recipients must be enrolled as an approved provider with that Department. Each individual recipient's treatment program is subject to the limitations established by the DMHDD and must be approved by the DMHDD Regional Director prior to the provision of services.

PROCEDURE: Physicians are to contact the DMHDD Regional Director (see General Appendix 4) for enrollment information, program requirements, and procedures for securing approval.

Subsequent to the provision of approved services physicians are to submit charges to the DMHDD Regional Office on forms specifically designated by that Department. After review and approval, bills will be forwarded to the Department of Public Aid for payment.

Consultations

Neither prior approval nor enrollment with the Department of Mental Health and Developmental Disabilities is required for the provision of a psychiatric consultation to determine the need for psychiatric care. However, any services provided subsequent to the initial consultation are subject to the requirements indicated above.

PROCEDURE: If the consulting physician is approved by the DMHDD for the provision of psychiatric services, charges for the consultation are to be submitted to that Department.

If the physician is not enrolled with the DMHDD, policy and procedure in Topic A-227 apply.

A-206. *Record Requirements*

Physicians must maintain an office medical record for each recipient-patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the specific physicians rendering service.

Basically, the record is to include the essential details of the recipient's health condition and of each service provided. All entries must be dated and legible.

Minimal record requirements satisfying Department standards for the various types of office visits are to be found in Topic A-220.

For recipients who are hospitalized or in a long term care facility, the primary medical record indicating the recipient's health condition and treatments and services ordered and provided during the period of hospitalization or institutionalization may be maintained as a part of the hospital or facility chart; however, an abstract of the hospital or facility record including diagnosis, treatment program, and recommendations, is to be maintained by the physician as an office record to show continuity of care.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, physicians should be aware that the medical records are a key document for post-audit of payments. In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped.

The Department's requirements on retention of records as stated in Item 11, Topic 111 in Section I, Chapter 100 are applicable to x-ray and similar records of a film-like nature. The requirements are not intended to replace professional judgment as to the length of time records are retained nor do they constitute a standard for legal purposes. The physician may choose to retain records beyond the Department's required period.

The Department has no objections to the microfilming of x-rays when it is done in compliance with applicable state laws.

A-210. PHARMACY ITEMS

Pharmacy items which are determined by the physician to be essential for the accepted treatment of a recipient's presenting symptoms and diagnosis are covered items for which payment can be made by the Department, when they are prescribed or dispensed in accordance with the following requirements and limitations.

The recipient's medical record in the physician's office is to contain entries regarding all drugs, medications, and medical supplies which are prescribed or dispensed, and the patient's response to the treatment.

A-211. *Allowable Items*

Pharmacy items, both prescription and over-the-counter items, which are covered in the Medical Assistance Program are listed in the Department Drug Manual and supplements thereto (see Section IV). Any item in the Drug Manual which is not excluded or limited (see Topic A-212) may be prescribed or dispensed in accordance with specified policy and procedure.

A-211.1 Drug Manual

The Drug Manual consists of the summary listing of the general categories of products which are included in the Medical Assistance program followed by the alphabetical listing, by either generic or trade name, of products included. Each product or general category listing is assigned a specific eight-digit item number.

* * *

A-212. *Exclusions and Limitations*

A-212.1 Exclusions

Pharmacy items which may not be prescribed or dispensed, with payment made by the Department are:

- Items not included in the Drug Manual (except for "Special Approval" items)
- Anorectic drugs or combinations including such drugs
- Biologicals and drugs available without charge from the Illinois Department of Public Health or other agencies (see Appendix A-9)
- Any vaccine, drug, or serum which is provided primarily for preventive purposes; e.g., influenza vaccine

- Vitamin B12 or liver extract except for patients with macrocytic anemia, e.g. pernicious anemia, the diagnosis of which is established on the basis of hematological studies
- Injectable drugs, when equally effective oral preparations are available
- Items such as dental products, hair products, facial tissues, infant disposable diapers, sanitary pads, tampons, soap or other personal hygiene products, articles of clothing or cosmetics of any type, proprietary food supplements or substitutes, sugar or salt substitutes, or household products
- Infant formula, except for infant requiring a non-milk base product because of an allergic reaction to the usual infant products

A-212.2 Limitations

Medical Supplies

Medical supplies are considered to be those items which are not durable or reusable as opposed to sick room needs and medical equipment items (see Topic A-212.3).

The provision of *medical supplies* is limited to those items that are required to be used by a recipient in the following of a treatment plan prescribed by the physician for a specific medical condition. Medical supplies are not to be prescribed only for a recipient's personal convenience.

Home Medicine Chest Items

Pharmacy items generally considered to be *home medicine chest items* may be prescribed only when an individual recipient's need for a specific item is extended or the item is required to be used in large quantities for a specific therapeutic reason. Such items include, but are not limited to: aspirin, cough medicine, throat lozenges, laxatives, Vaseline, gauze, adhesive tape, rubbing alcohol, etc.

Group Care Restricted Items

Pharmacy items identified in the Drug Manual as *Group Care Restricted Items* may not be prescribed for recipients living in licensed long term care facilities. Payment to the facility includes payment for the provision of such items.

* * *

A-220. OFFICE SERVICES

Medical and surgical services which are essential for the diagnosis and/or treatment of a specific illness, symptom, or injury are covered when provided by a physician or by his office staff in his office under his direct supervision.

All office services for which charges are made must be documented in the recipient's office medical record.

Six types of office visits are recognized by the Department. Each visit for which a charge is made is to be correctly identified by the physician by use of the designated procedure code. Statements submitted with any other office visit procedure code entered are subject to return to the physician for correction.

1) *Initial Visit, New Patient*—The first visit of a patient whom the physician (or any other physician in the same group or office) has not seen before. The visit includes a limited history, a limited physical examination to the extent necessary to arrive at a provisional diagnosis, and a medical evaluation in response to presenting complaints and symptoms. Treatment is initiated and medical advice and direction given.

This type of visit is allowed *only one time* by a physician for an individual patient. In partnership or group practices, it is allowed only one time collectively for all physicians in the group regardless of the number of physicians in the group who eventually may see the recipient.

Medical Record Documentation Required—In addition to the symptoms and complaints, a limited past history; a statement of onset and course of the present condition; the physical examination findings; the laboratory and x-ray procedures ordered and their results; the provisional diagnosis; treatment given or recommended; and follow-up advice given should be listed as outlined for a comprehensive diagnostic visit.

PROCEDURE: Procedure Code *90010* is to be used to identify charges for this type visit.

2) *Routine Visit*—The most common type visit. Return visit of an established patient for examination and treatment by the physician of new complaints and symptoms, or for re-check by the physician of the previous condition and response to continuing treatment.

Medical Record Documentation Required—Symptoms or complaints (or changes therein); the onset, duration, and course of illness; history of past similar conditions and past individual history, as pertinent (allergies, etc.); physical examination findings relating to the affected area; the diagnostic procedures ordered and their results; provisional diagnosis; treatment given or recommended and advice given should be listed as outlined for a comprehensive diagnostic visit.

PROCEDURE: Procedure Code *90040* is to be used to identify charges for this type visit.

3) *Comprehensive Diagnostic Visit*—Because of the time element involved and the complexity of the examination, this is the least common type of office examination. Includes complete personal, family, allergy, and immunization history, thorough systems review and physical examination, medical evaluation and diagnosis by physician, discussion of condition with patient, initiation of treatment program, immediate and projected, and the giving of medical advice and direction to the recipient and family, as appropriate.

Medical Record Documentation Required—

Presenting symptoms and complaints
Family history (mother, father, etc.)
Individual past history
- illnesses, surgery, accidents, etc.
- allergies, sensitivities
- immunizations
- psychiatric conditions
- habits—smoking, alcohol, drugs, etc.
- weight gains or losses

Onset and course of present illness, including previous episodes
Review of systems, including past conditions
Physical examination findings—including unrelated abnormal findings as well as those pertinent to present illness
Investigative procedures such as laboratory and x-ray examinations—listing of all diagnostic procedures ordered, when, where and reports of findings of each
Copy of any consultation reports requested
Provisional diagnosis or problem oriented impression, including other possible diagnoses, if appropriate
Treatment record—injections given (what, amount, etc.); medications prescribed or dispensed (what, amount, dosage, etc.); any other medical treatment given; surgical treatment given or recommended
Recommendations for follow-up or subsequent treatment
Other details and specifics as the condition of the recipient may require

PROCEDURE: Procedure Code *90020* is to be used to identify charges for this type visit.

4) *Intermediate Visit*—A visit by an established patient at which time a complete re-evaluation and physical examination *are necessary* for diagnostic purposes and are done by the physician. Includes initiation of treatment and the giving of medical advice and direction.

This type of visit is not routine and is considered necessary only when changes in the presenting symptoms and complaints are such that an additional in-depth re-evaluation is required to confirm diagnosis and treatment program.

Medical Record Documentation Required—Of prime importance is the description of new complaints and symptoms (or changes in previous ones), or the lack of anticipated improvement which necessitates the need for a complete evaluation. Good or adverse results of treatment and new or changed physical findings since previous visit(s) should be listed. New laboratory or x-ray procedures and their results, additional or secondary diagnoses and revisions or new modes of treatment are to be recorded. Intended follow-up policy should also be shown.

PROCEDURE: Procedure Code *90070* is to be used to identify charges for this type visit.

5) *Minimal Visit*—Brief return visit not necessitating evaluation and examination. To be used, for example, when injections are given or dressings applied, or when only progress and response to treatment and/or medications is checked.

Medical Record Documentation Required—The record must show *what* was done and by whom. In the event of any adverse or questionable progress, a notation should be made. Advice for future treatment is to be listed.

PROCEDURE: Procedure Code *90030* is to be used to identify charges for this type visit.

6) *Referral (Transferred Patient)*—A referral applies to services provided a recipient-patient who is sent by one physician to another for diagnosis and/or treatment. In

reality this is a transfer of a patient, the receiving physician most frequently being a specialist or in a different field of practice than the referring physician.

A patient acquired in such a manner is considered to be a transferred patient and the visit classified the same as any first visit to that physician—initial visit, new patient. Coding should be consistent with complexity of condition.

Visits of referred (transferred) patients are *not* considered, and may not be billed as, consultations. (See Topic A-227 for definition and services of consultants.)

PROCEDURE: Procedure code *90010* is to be used for the great majority of initial visits of referred patients. In unusual and exceptional cases of great complexity, procedure code *90020* may be used if warranted. While no written report of the examination and findings is required to be sent to the referring physician, his name must be entered on Form DPA 132 when submitted for payment.

At the time of an office visit, the physician may provide medical and/or surgical procedures. When a procedure is performed, a charge may be made for either the visit or the procedure, but not for both.

A charge may be made for a physical examination provided to a child in accordance with the requirement of the Illinois School Code for such an examination for all pupils entering kindergarten or first grade, fifth, and ninth grades, only if the child is not receiving scheduled Medichek services. The Medichek examinations at ages 5, 6, 10 and 14 meet school examination requirements and, therefore, are not to be duplicated.

PROCEDURE: Procedure code *90034* is to be entered on Form DPA 132 to identify the service charge and the school grade level for which the examination was given is to be included.

When a charge is made for a school physical examination, the recipient child's medical record in the physician's office is to include a report of the examination findings and clearly indicate the child's non-participation in the Medichek Program.

A-221. *Medical Diagnostic and Treatment Services*

A-221.1 Laboratory Tests

Only those laboratory tests and examinations which are essential for diagnosis and control are covered. Laboratory tests must be consistent with good medical practice.

Routine screening tests are not covered, except as specified for provision under the Medichek Program.

A physician may charge only for those tests done in his office, by his own staff, using his equipment and supplies.

Charges may not be made, nor is a physician to make referral, for laboratory tests which are provided by the Illinois Department of Public Health without charge (see Appendix A-10); except that, the physician may either do in his office laboratory and make charges, or make referral, for essential throat and urine cultures in instances in which use of the Department of Public Health laboratory would result in delay in diagnosis and treatment.

PROCEDURE: Charges for throat and urine cultures done in the physician's office are to be coded on Form DPA 132 as follows;

Code *87081* Culture (throat) Screening for organism
Code *87082* Culture (urine) Screening for organism
Code *87091* Culture (throat) Definitive for organism
Code *87092* Culture (urine) Definitive for organism

Charges may not be made for sensitivity studies when a culture shows no growth or when a growth is identified as beta hemalytic streptococcus.

A central laboratory serving physicians in group practice is considered a physician's office laboratory, unless the laboratory is a Medicare certified independent laboratory.

When laboratory tests only are done, an office visit charge may not be made.

PROCEDURE: Charges for office laboratory tests are to be submitted on Form DPA 132. Common laboratory tests are precoded in Part B, Section 2.2. A test which is not precoded is to be shown in Section 3, with the date and place of service indicated. If any one test is done more than one time in the month, a separate entry is necessary.

Profile or panel tests are to be done only when essential and must be so identified.

PROCEDURE: When charges are made for an SMA 12, procedure code 89370 is to be used in Section 3. It is not necessary to list the individual test included in this panel.

Procedure code 89371, lab profile tests, precoded in Part B Section 2.2 is to be used for all other profile tests. *The name of each test in the panel is to be specified in Section 3.*

For necessary laboratory tests not done in the physician's office, the physician may make *written* referral to 1) the outpatient department of a participating hospital, 2) a pathologist in private practice, or 3) a Medicare certified independent laboratory. When referral is made, the physician must specify the tests ordered. Blanket, "rule out", or open-ended requests are not allowed. The physician must use discretion in ordering only those laboratory tests necessary and pertinent to the condition which he is treating. No payment will be made to a laboratory for tests done which are not consistent with the diagnosis.

The physician may not charge for making referral, for obtaining or sending of a specimen for analysis, or for tests ordered.

In each instance, the provider of services is to make charges direct to the Department and provide a written report of test results to the physician for filing in the recipient's medical record.

When referral is made to an independent laboratory, the physician must include his AMA Medical Education number and the recipient's diagnosis or presenting symptoms which indicate the need for the specific tests ordered.

A pathologist in private practice may charge for the specific tests and examinations provided, however, an additional office visit charge may not be made. If the pathologist has his office laboratory certified by Medicare as an independent laboratory, independent laboratory policy and procedure apply.

A hospital based pathologist may submit charges to the Department for his professional services in connection with referred laboratory services only if his contractual agreement with the hospital provides for separation of charges.

PROCEDURE: Charges for the professional component of laboratory services are to be submitted on Form DPA 132 with appropriate procedure codes. The place of service is to be shown as "OH", Outpatient Hospital.

A-221.2 X-Ray Services

X-ray services are covered when essential for the diagnosis and treatment of disease or injury. Routine screening x-rays are not covered.

Ultrasound imaging, scanning, echograms or sonograms are covered only when essential and then only in unusual circumstances, such as a variation from the normal or from normal progress of a condition which would be detectable by such a procedure. Routine screening or surveys are not allowed, nor are "rule out" examinations unless a specific differential problem exists.

PROCEDURE: Procedure codes 95950 through 95982 are to be used as appropriate. The procedure code, date, and place of service ("0") are to be entered in Section 3 of Form DPA 132. The physician must include a provisional diagnosis or sufficient explanation of the abnormal condition for which the service was provided.

When a charge is made for ultrasound examinations, an additional charge may not be made for radiographic examinations of the same area or systems unless adequate justification is given for both procedures.

A physician may charge only for x-ray examinations done in his own office, by his own staff, using his equipment and supplies.

A central x-ray department serving physicians in group practice is considered the physician's office.

PROCEDURE: Certain x-ray examinations are precoded in Part B, Section 2.3 of Form DPA 132. If a specific type x-ray is not precoded, it is to be reported in Section 3. The date and place of service (indicated as "O" for Office) are to be entered for each x-ray for which a charge is made.

When x-rays only are provided at the time of an office visit, an office visit charge may not be made.

When it is necessary for a physician to read comparison x-rays, and it is his usual and customary practice to make an additional charge for this service, procedure code *76490* is to be used to identify the charge.

The physician may make written referral, for a recipient to have x-ray examinations or therapy, to a hospital outpatient department or to a radiologist in private practice. The physician may not charge for the referral. The provider of the x-ray services is to make charges direct to the Department. The charge for x-rays includes the provision of a written report to the referring physician, which he is to file in the recipient's medical record.

A radiologist in private practice may charge for the specific x-ray examinations or therapy provided. Additional office visit charges may not be made.

PROCEDURE: When therapy treatments are provided, the appropriate procedure code, date, and place of service ("O") are to be entered in Section 3 of Form DPA 132 for each treatment given.

A hospital based radiologist may submit charges to the Department for his professional services in connection with referred x-ray services if his contractual agreement with the hospital provides for separation of charges and the hospital does not bill.

PROCEDURE: Charges for the professional component of x-ray services are to be submitted on Form DPA 132 with the appropriate procedure codes and date(s). The place of service is to be shown as "OH", Outpatient Hospital. When x-ray therapy is given, the date, procedure code, and place of service ("OH") are to be entered in Section 3 for each treatment.

If a charge is made for the use of portable x-ray equipment, the use of such equipment requires prior approval of the local Public Aid office.

* * *

A-222. *Surgical Services*

Essential minor surgical procedures which are customarily done in the physician's office are covered services. When charges are made for a surgical procedure, an additional charge may not be made for an office visit.

PROCEDURE: The procedure code for the specific surgical procedure is to be entered. A description of the procedure, e.g. size of lesion, number of sutures, removal procedure, etc., is to be provided.

The procedure code for office cryosurgery without biopsy and without dilation and curettage is 57513.

A charge may not be made for post-operative office visits and treatment following major surgery for a minimum of 30 days.

A-222.1 Anesthesia

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

A-222.2 Dressings

For customary surgical dressings no charges may be made in addition to office visit or procedure charges. For dressings which are unusually expensive or required in large amounts, e.g. medicated dressings, charges may be made if substantiating clinical data is submitted.

A-223. *Burn Treatment*

Charges may be made for surgical debridement and dressings for burns, when substantiating information is submitted. No additional charge may be made for the office visit.

PROCEDURE: Procedure codes *16000* through *16030* are to be used. The location of the debridement and the size, in centimeters, of the area debrided are to be included. Also, the cost to the physician of the burn dressings is to be included.

A-224. *Eye Care*

Ophthalmologists and other physicians skilled in treatment of diseases of the eye and its appendages may provide eye care and treatment. Services which may be provided include: 1) those required to determine the presence of disease and whether treatment is indicated; 2) essential medical and surgical treatment; 3) the determination of the refractive state of the eyes; and 4) the prescribing and provision of glasses and other ophthalmic supplies.

A-224.1 Medical and Surgical Diagnostic and Treatment Services

Provisions of Topics A-221, A-222, and A-240 regarding office and hospital services apply when eye care is provided.

Diagnostic ophthalmological procedures which may be provided are listed in Appendix A-11. The provision of any other procedure requires prior approval.

PROCEDURE: The appropriate procedure code designated for the specific procedure is to be entered on Form DPA 132. When prior approval is required, a written request is to be submitted by the physician, with pertinent medical information, to Illinois Department of Public Aid, Post Office Box 4035, Springfield, Illinois 62708. Notification of approval or disapproval of the request will be sent to the physician. If the request is approved, a copy of the approval notice is to be attached to the Form DPA 132 used for billing.

Muscle surgery may be provided in a case in which improvement in vision or binocular function is the objective. Muscle surgery for cosmetic purposes may be provided for children having a deviation of 20 or more prism diopters for distance or near fixation. Muscle surgery for cosmetic reasons for adults requires prior approval.

PROCEDURE: A written request for approval to provide muscle surgery for an adult recipient is to be submitted by the physician to Illinois Department of Public Aid, Post Office Box 4035, Springfield, Illinois 62708. The request is to include pertinent medical information which substantiates the need for the surgery. If the request is approved, the physician is to attach a copy of the approval notice to the Form DPA 132 used for billing.

A-224.2 Determination of the Refractive State of the Eyes

This service is not covered for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97), unless specifically requested by the Department in individual cases. In such instances, the recipient will have written authorization from the Department to present to the physician.

Except in unusual circumstances, no more than one refraction per year is allowed.

When a charge is made for a refraction, an additional charge may not be made for the prescription for glasses, if needed, or for the re-examination to check the glasses provided.

PROCEDURE: If the only service provided in a given month is a simple refraction and glasses are dispensed (see Topic A-224.3), Form 136 is to be used as the billing statement for both the refraction and the glasses. (See Appendix A-2 and A-2a.) If a simple refraction is the only service and glasses are not dispensed by the physician, Form DPA 132 is to be used and the charges for the refraction listed with procedure code 92034.

A-224.3 Provision of Glasses and Ophthalmic Supplies

This service is not covered for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97), unless specifically requested by the Department in individual cases. In such instances, the recipient will have written authorization from the Department to present to the physician.

A physician may dispense glasses and other ophthalmic supplies or he may give the necessary prescription to the recipient to take to the optician of his choice.

Charges are to be made for glasses and other supplies, exclusive of frames, at a cost plus 15%. Payment will be made as charged, if reasonable.

PROCEDURE: If the physician dispenses, Form DPA 136 is to be used to submit charges to the Department. When artificial eyes or prosthetic lenses for aphakic patients who are eligible for Medicare benefits are dispensed, Form DPA 136 is not to be submitted to the Department until the Explanation of Benefits is received from the Medicare intermediary. Form DPA 136 is then to be attached to a copy of the SSA 1490 and a copy of the Explanation of Benefits and submitted. (See Chapter 100, Topic 122.1.)

If the physician does not dispense, he is to write the prescription on Form DPA 136 to be given to the optician in duplicate. The optician will subsequently use the form for submittal of his charges.

The physician is to dispense or prescribe in accordance with the following requirements.

A-224.31 Lenses

Initial lenses may be provided only when the total correction in one eye is at least 0.75 diopters.

A subsequent change of lenses may be provided only when the difference between the previous prescription and the new prescription is at least 0.75 diopters in one eye.

Lenses must be impact resistant.

Lenses must be first quality as defined by the American Standards Association and must meet Federal regulations.

Glass lenses must be furnished without defects or imperfections, such as chips, bubbles, or scratches.

A-224.32 Frames

New frames may be provided through the Medical Assistance Program when necessary. They are not to be provided based only on a recipient's preference for a change in style, color, etc.

A-224.33 Repairs and Replacement

Frames are to be repaired and parts replaced when possible rather than new frames dispensed. Whenever possible, old frames are to be used when a lens needs to be replaced or when new lenses are prescribed. When a frame is not repairable and a new frame is needed, old lenses are to be used unless a change in prescription is required.

A-224.34 Dispensing Fee

A charge may be made for dispensing if it is the physician's customary practice to make such a charge. The charge covers the glasses case and any necessary mailing costs.

A-224.35 Prior Authorization Requirements

The following articles may be provided only with prior authorization of the Department:

- Lenses which do not meet stated specifications. (See Topic A-224.31.)
- Tinted or plastic lenses
- Spare glasses
- Trifocals (replacement does not require prior authorization)
- Special ophthalmic supplies such as contact lenses, subnormal visual corrective devices, or custom-made artificial eyes

PROCEDURE: The physician is to request prior approval to dispense or prescribe by submitting Form DPA 136, Complete except for signature and date of service, in duplicate, to

Illinois Department of Public Aid
Bureau of Special Medical Operations
2036 South Michigan Avenue—Second Floor
Chicago, Illinois 60616

An explanation of the need for the specific item is to be given. Approval or disapproval of the request will be entered on the forms and both copies returned to the physician.

If the request is approved and the physician dispenses, he is to use the original copy of the form, on which approval is indicated, as his billing statement after the items have been provided.

If the request is approved and the physician does not dispense, both copies which have been returned to him, with approval indicated, are to be sued as his prescription and given to the optician for filling and subsequent billing.

A-225. *Medichek Services*

These services are not covered for recipients of General Assistance or Aid to the Medically Indigent (Categories 07 and 97).

The Medichek Program provides for children from birth through age 20 to receive periodic screening and diagnostic services to detect or prevent physicial and mental defects. Allowable services are:

1) scheduled medical examinations beginning at 6 weeks of age, and
2) immunizations.

To provide Medichek services, a physician must be enrolled with the Illinois Department of Public Health. All billing statements for Medichek services are submitted to that Department.

PROCEDURE: For enrollment information, program explanation, and specific billing procedures and forms for Medichek services, the physician is to contact the Medichek coordinator in the local Public Aid Office

If as a result of Medichek screening services, a condition is detected which requires further diagnostic procedures and/or treatment, such services may be provided if they are covered services under the Medical Assistance Program. Charges for these services are to be submitted to the Department.

PROCEDURE: Form DPA 132 is to be used for billing for treatment provided as the result of Medichek screening services. Charges for the Medichek services are not to be included.

A-226. *Family Planning Services*

Services and supplies for the purpose of family planning are covered regardless of age, sex, or marital status. The physician may provide a physical examination, including breast examination, pelvic examination, and Pap smear. Contraceptive supplies may be dispensed or prescribed or ordered.

PROCEDURE: One all-inclusive charge is to be made for the office visit and physician's services provided for family planning purposes.

When an intrauterine device is inserted, procedure code 58300 is to be used. If a charge is made for the device, procedure code 99200 is also to be entered along with information as to type and cost to the physician.

When an intrauterine device is not inserted, procedure code 90041 is to be entered.

An additional charge may be made for a Pap smear *only* if the physician does the laboratory examination in his own office laboratory.

A-227. *Consultations*

A physician may request the service of another physician when essential for diagnosis and/or treatment recommendations.

The Department considers a consultation to be a deliberation of two or more physicians with respect to the diagnosis and/or treatment in any particular illness or condition involving a recipient, with the consultant *not* assuming direct care of the recipient. If the consultant does assume direct and daily care, he is then considered to be the attending physician in lieu of the physician formerly providing such care.

In making charges for a consultation, a written report is to be made a part of the recipient's record in both the consulting and requesting physician's records.

PROCEDURE: A procedure code of 90600 through 90630, as appropriate, is to be used to identify a charge for a consultation. (NOTE: These codes are *not* to be used for *Referrals* as defined in Topic A-220.)

Information must be entered on Form DPA 132 submitted by the consultant that he performed the service as a consultant rather than as the attending physician. The name of the physician who requested the consultation must also be entered on the billing form.

If, subsequent to a consultation, the physician consultant provides direct or continued care to the recipient, all subsequent services will be considered as provided in the role of attending physician. The consultation will then be considered to be the initial comprehensive visit and subsequent charges for this service may not be made.

A presurgical examination by the operating surgeon is considered an essential element of the surgical procedure and is not reimbursable as a consultation.

Charges may not be made to the Department for a consultation, a medical opinion or a report which is requested by another party or agency.

* * *

A-242. *Inpatient Services*

A physician may admit a recipient for essential inpatient hospital services in connection with covered treatment of an illness or injury.

A-242.1 Utilization Review

The medical need for hospital admission and the length of the hospitalization are monitored and controlled by:

- The Hospital Admission and Surveillance Program (HASP)

or

- The Hospital Utilization Review Committee (URC)

or

- The Department of Mental Health and Developmental Disabilities (DMHDD)

HASP controls hospitalization of recipients not eligible for Medicare benefits. The hospital URC controls hospitalization of the recipients eligible for Medicare benefits. The DMHDD controls hospitalization of recipients admitted for inpatient psychiatric services.

Limitations are placed on length of stay according to diagnosis and specific need of the individual recipient for hospital care.

The physician will be notified by the representatives of the appropriate monitoring authority when a determination has been made that continued inpatient hospitalization is not essential. If the recipient is not discharged within 72 hours after such a determination is made, payment by the Department for any additional period of hospitalization will cease. Additionally, payment for physicians' services provided during the unauthorized period of hospitalization will be denied.

PROCEDURE: If a physician questions a determination that continued hospitalization is non-essential, he should contact the Chairman of the URC, the HASP Coordinator for the hospital, or the DMHDD Regional Office, as appropriate.

If the physician desires the assistance of the local Public Aid caseworker in making arrangements for care after discharge, he should contact the local Public Aid office.

A-242.2 Surgery

Covered surgical procedures which are medically necessary are allowable.

The charge made for an operative procedure includes complete post-operative care for a minimum period of 30 days, including customary wound dressings.

When a charge for surgery is greater than the physician's usual and customary fee for the procedure, based on the operation being seriously complicated by factors not usually present, the physician is to submit clinical data adequate to support the claim.

When multiple surgical procedures are performed through the same incision, payment will be based on charges for the major procedure.

For material of significant value such as orthopedic pins and nails, which are supplied by the physician, payment will be made based on cost to the physician.

PROCEDURE: The appropriate procedure code for the specific surgical procedure is to be entered on Form DPA 132. When higher than usual charges are made for a complicated procedure, complete clinical information is to be included. The procedure code for the major procedure is to be used when multiple procedures are performed. When charges are made for materials supplied by the physician, the description of the material and cost to him are to be specified and procedure code 99200 entered.

When cryosurgery is done with extensive conization and with biopsy and dilation and curettage, the procedure code to use is 57515.

* * *

Chapter H-200

Hospital Services

The Illinois Medical Assistance Program provides payment for hospital services in the following categories of service for eligible Public Aid recipients:

- Inpatient Hospital Services (General)
- Inpatient Hospital Services (Psychiatric)
- Inpatient Hospital Services (Physical Rehabilitation)
- Inpatient Hospital Services (End Stage Renal Disease)
- Outpatient Hospital Services (General)
- Outpatient Hospital Services (End Stage Renal Disease)
- Clinic Services (General)
- Clinic Services (Psychiatric A)
- Clinic Services (Psychiatric B)
- Clinic Services (Physical Rehabilitation)
- Medichek Screening Services

For consideration to be given by the Department to payment for hospital services, the services must be provided by a participating hospital that is enrolled for the specific category of service for which charges are made and the services must be provided in full compliance with the policy and procedures contained in the various sections of this Handbook.

H-200 BASIC PROVISIONS

H-201 *Participation*

To participate in the Illinois Medical Assistance Program, a hospital must meet the requirements of Topic H-201.1. Any additional participation requirement(s) that must be met for enrollment to provide a specific category of service are specified subsequently in this chapter under the appropriate topic.

H-201.1 Requirements

The following requirements must be met by a hospital to qualify for enrollment:

1. The hospital must hold a valid license issued by the State in which the hospital is located;

2. The hospital must be certified by the Social Security Administration for participation in the Medicare Program (Title XVIII);

or

if not eligible for or subject to Medicare certification, must be accredited by the Joint Commission on the Accreditation of Hospitals;

3. The hospital must agree to accept the Department of Public Aid basis for reimbursement;

4. The hospital must enroll and sign Form DPA 1431, Hospital Agreement.

PROCEDURE: The hospital is to complete and submit:

- Form DPA 1420, Hospital Enrollment Form
- Form DPA 1431, Hospital Agreement

The required forms are to be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708

The original copy of each form must be completed (printed in ink or typewritten), signed and dated in ink by the chief administrative officer of the hospital and returned to the above address. A copy of each completed form is to be retained by the hospital.

The hospital will be notified by the Department of approval or denial of participation.

H-201.2 Participation Approval

When participation is approved the hospital will be sent a computer-generated notification, the Provider Information Sheet, reflecting all identifying data regarding the hospital, the categories of service the hospital is enrolled to provide, the effective date of enrollment for each category, the approved reimbursement rate and the forms request information. See Appendix H-20 and H-20a for a sample of the Provider Information Sheet and related explanation.

In instances in which a hospital is enrolled to provide services in a location apart from the hospital, a separate Provider Information Sheet will be prepared for each separate location showing the unique provider number assigned. Appropriate data, as indicated above, will be listed for all categories of service that may be provided at the specific location.

H-201.3 Participation Denial

If it is necessary for any reason to deny participation, written notification will include the basis for such a determination. Within 10 days of the date of such notice, the hospital may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within 10 days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. (See Section III, General Appendix 7A, Rules for Department Actions Against Medical Vendors, and General Appendix 7B, Rules of Practice for Medical Vendor Administrative Proceedings.)

H-201.4 Provider File Maintenance

The information carried in Department files for participating providers must be maintained on a current basis. The hospital and the Department share responsibility for keeping the file updated.

H-201.41 *Hospital Responsibility*

The information contained on the Provider Information Sheet is that carried on Department files. Each time the hospital receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. Inasmuch as the Provider Information Sheet contains information to be used by the hospital in the preparation of billing statements, any inaccuracies found are to be corrected and the Department notified immediately.

PROCEDURE: The hospital is to line out erroneous information and enter corrected data in the space below the error and forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708

Any time a hospital makes a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified in the same manner as indicated in the preceding paragraph. When possible, 30 days minimum notification should be made in advance of a change in order to allow updating of Department files.

Failure of a hospital to properly notify the Department of corrections and/or changes may cause an interruption in participation and/or disrupt the normal payment process.

H-201.42 *Department Responsibility*

Whenever there is a change in enrollment status; i.e., approval is given or withdrawn for the provision of a specific category of service, an updated Provider Information Sheet will be generated indicating the change, the effective date and, if appropriate, the approved rate.

Whenever there is a change in the approved interim reimbursement rate for a hospital, an updated Provider Information Sheet will be generated indicating the new rate and the effective date.

H-202 *Reimbursement*

Reimbursement to participating hospitals is based on annual cost reconciliation information.

H-202.1 Hospitals Exempt From Submittal of Cost Information

Those out-of-state hospitals *which are exempt from submitting cost information,* because they serve few Illinois Department of Public Aid clients, are reimbursed at the same rate of reimbursement as that authorized for Title XIX recipients in the State in which the hospital is located.

H-202.2 Hospitals Required to Submit Cost Information

Cost reports are required from all Illinois hospitals and all out-of-state hospitals anticipating 200 inpatient census days of service to recipients of the Illinois Medical Assistance Program.

The Department's rate of payment to all Illinois hospitals and all out-of-state hospitals required to submit cost information is individualized by hospital and is based on reasonable costs which do not exceed the reimbursement under Title XVIII (Medicare) methods of apportionment. Costs not allowable under Title XVIII are not considered in determining rates under Title XIX (Medicaid).

The reimbursement system for these hospitals is a retrospective rate setting system with payment rates based on the hospital's latest annual cost report as filed by the hospital and desk and field audited by the Illinois Department of Public Health, Office of Health Finance. Cost analysis by that office or its authorized agent provides the Department of Public Aid with the information necessary to, 1) establish reimbursement rates for hospital services and 2) reconcile past payments with operating costs for the same fiscal period.

The approved rate and the effective date, appropriate for the category of service the hospital is enrolled to provide, are shown on the Provider Information Sheet. The rate charged by the hospital when billing the Department for services rendered to Public Aid recipients must be the appropriate rate in effect for the category of service on the date the service was provided. When a new rate is approved, an updated Provider Information Sheet will be sent to the hospital showing the new rate and the effective date.

H-202.21 *Preparation and Submittal of Cost Information*

Upon application for participation in the Medical Assistance Program, the Office of Health Finance, Illinois Department of Public Health, will supply the appropriate forms and instructions for completion of the Hospital Statement of Reimbursable Cost. Directions for maintaining a separate hospital log for both inpatient and outpatient services, reimbursed by the Department of Public Aid, will be provided by that office. The separate log for each of the two types of services should combine service information for all recipients of the following categories: 00, 90, 01, 91, 02, 92, 03, 93, 04, 94, 95, 06, 96 and 98. A separate log for General Assistance and Aid to the Medically Indigent (categories 07 and 97) must be kept for each payor (township or commission). A separate log also must be kept for Migrant Medical Program cases (category 97). Where Third Party payments equal or exceed the Department's approved rate, the hospital may elect to include or exclude these costs from the hospital's log and subsequent reconciliation.

Cost information must be submitted *annually within 90 days of the close of the hospital's fiscal year.* The Office of Health Finance will send the required forms and instructions to the hospital each year approximately ten days prior to the close of the hospital's fiscal year. The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted for review as directed by

the Office of Health Finance. If the cost information is not submitted on a timely basis, the Department of Public Aid will temporarily suspend processing of any bills from hospitals whose cost reports are delinquent. The processing of bills will resume after the cost report is received and reviewed by the Office of Health Finance.

Generally, payment rates are based on the latest annual cost report filed by the hospital; however, at the option of the hospital, an interim rate adjustment can be made no more than semi-annually based on six or more months' data from the hospital's current fiscal year. Office of Health Finance should be contacted to request an interim rate review.

Written inquiries regarding the preparation and submittal of the cost statement are to be directed to:

Illinois Department of Public Health
Office of Health Finance
525 West Jefferson Street
Springfield, Illinois 62761

Telephone inquiries are to be directed to (217) 782-6235.

H-202.22 *Reconciliation*

Annually, payment made at interim rates during the hospital's fiscal year will be reconciled to reasonable allowable costs.

At the request of the hospital, a preliminary settlement will be made within 60 days of the cost report filing date in an amount equal to 70 percent of the amount claimed by the provider or due the Department of Public Aid on the cost report as submitted (as adjusted for obvious errors or inconsistencies).

Based on a desk audit, a full reconciliation amount usually will be processed for payment to or collection from the hospital within 90 days of filing of the cost report. The reconciliation is not considered to be final, however, until a field audit has been made.

AABD, AFDC, MANG, REFUGEE/REPATRIATE PROGRAM

If payments made to the hospital during its fiscal year exceed the amount which would have been paid at the rates approved for the hospital by the Department, the excess will be credited against future obligations of the Department or refunded to the Department. If payments were less than cost, supplementary payment to the hospital will be made by the Department.

GA, AMI

If payments made to a hospital during its fiscal year exceed the amount which would have been paid at the final cost determined for the hospital by the Department, the excess will be credited against future obligations of the Department (or township or commission) or refunded to the Department (or township or commission).

MIGRANT MEDICAL PROGRAM

If payments made to the hospital during its fiscal year exceed the amount which would have been paid at the reimbursable rates approved for the hospital by the Department, the excess will be credited against future obligations of the Department or refunded to the Department.

H-203 *Covered Services*

The Medical Assistance Program provides for essential inpatient, outpatient and clinic diagnostic and treatment services that are provided to recipients by participating hospitals.

To qualify for payment, all hospital services must be provided in accordance with policy and procedure as set forth in this Handbook.

H-204 *Services Not Covered in the Medical Assistance Program*

Certain services are not covered in the scope of the Medical Assistance Program and payment cannot be made for their provision to Public Aid recipients. Such services include the following.

1. Services prohibited by Illinois or Federal statutes.

2. Services available without charge.

3. Care provided by or in Federal hospitals.

4. Care provided by a hospital located in Illinois which is not enrolled in the Medical Assistance Program.

5. Experimental medical or surgical procedures.

6. Autopsy examinations.

7. Research oriented procedures.

8. Medical or surgical transsexual treatment services.

9. Diagnostic and/or therapeutic procedures related to primary infertility/sterility.

10. Acupuncture.

11. A hysterectomy performed solely for the purpose of rendering an individual permanently incapable of reproducing (see Topic H-214.14 for additional clarification).

12. Abortion except when a) performed prior to fetal viability and a licensed physician in Illinois certifies in writing that the procedure is medically necessary; or b) when performed prior to or after fetal viability, it is certified in writing i) by a licensed physician in Illinois that the life of the mother would be endangered if the fetus were carried to term, or ii) by the two licensed physicians in Illinois that severe and long lasting physical health damage to the mother would result if the fetus were carried to term, or iii) that the abortion is necessary for a victim of rape or incest when the rape or incest was reported promptly to a law enforcement agency or public health service (See H-214.15).

13. Medical examinations required for the determination of eligibility for assistance. (Local Public Aid offices may request that these examinations be provided with payment from non-medical funds. Hospitals are to follow specific billing procedures given when such a request is made.)

14. Preventive services, with the exception of those provided through the Medichek Program for children through age 20 including required school examinations.

15. Artificial insemination.

16. Surgery for cosmetic purposes.

17. Non-medically necessary items and services provided for convenience of recipients and/or their families such as radios, televisions, telephone calls, meals and quarters for relatives, etc.

18. Preparation of routine records, forms and reports.

Should a hospital have a question regarding the inclusion of any other service, the Department is to be contacted at Post Office Box 4034, Springfield, Illinois 62708.

H-205 *Services Not Covered as Hospital Services*

Some services, although included in the Medical Assistance Program and under certain circumstances provided in the hospital setting or by an entity associated with the hospital, are not considered by the Department as a "hospital" category of service. (See Topics H-205.1 to H-206.)

Whenever a hospital has a question as to whether a particular service is covered, the Department is to be contacted at Post Office Box 4034, Springfield, Illinois 62708. (Telephone (217) 782-0496.)

H-205.1 Private Duty Nursing Services

Hospitals may not enroll to provide private duty nursing services.

Hospitals are expected to provide all required nursing services and, generally, persons requiring special nursing care are placed in an intensive care unit. Only in extraordinary instances in which a recipient's condition or the type of care needed requires many more hours of professional nursing service than the hospital can be expected to provide will approval of a private duty nurse, either a registered nurse or a licensed practical nurse, be considered by the Department.

Prior to making arrangements for private duty nursing services, the attending physician or the hospital at the physician's request is to contact the local Public Aid office to provide specific information regarding the need for the services in order to obtain prior approval. When private duty nursing services are approved by the local office for an individual recipient, the nurse submits charges to the Department and direct payment is made to the nurse.

H-205.2 Sitter Services

Hospitals may not enroll to provide sitter services.

Sitter services are provided only in those rare instances in which the condition of a hospitalized recipient necessitates a sitter to watch at the bedside. Consideration will be given to approval by the Department only in those unusual cases in which hospital staff, volunteers, relatives or friends of the recipient are unable to provide the services.

Prior to making arrangements for sitter services, the attending physician or the hospital at the physician's request is to contact the local Public Aid office to provide specific information regarding the need for sitter services in order to obtain prior approval. When the services are approved for an individual recipient, the person providing the services submits charges to the Department and direct payment is made to that individual.

H-205.3 Dental Services

Hospitals may not enroll to provide dental services.

When dental services are provided in the outpatient/clinic setting of a hospital, the dentist submits charges to the Department and direct payment is made to the dentist.

H-205.4 Long Term Care Services

Long term care services are not considered by the Department to be hospital services.

Hospitals, which have 1) a special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program or 2) a special unit or separate facility administratively associated with the hospital and licensed as a long term care facility, may not utilize such beds or facilities for hospital services.

If the hospital desires to receive payment for services provided to recipients utilizing these facilities, it is necessary for the hospital to apply for participation as a long term care facility.

Information regarding participation requirements and enrollment procedures for the provision of long term care services may be obtained from:

Illinois Department of Public Aid
Bureau of Group Care Services
931 East Washington Street
Springfield, Illinois 62763
Telephone (217) 782-0549

H-205.5 Pharmacy Services

The provision of pharmaceutical items and supplies to Public Aid recipients by the hospital pharmacy is not considered by the Department to be a hospital service when any pharmacy item or supply is dispensed to a recipient who is a patient in:

a) a specified bed or special hospital unit which is certified for skilled nursing facility services under the Medicare Program;

and/or

b) a special hospital unit or separate facility which is administratively associated with the hospital and is licensed as a long term care facility.

If the hospital desires to receive payment for pharmacy services provided under the specified circumstances, it is necessary for the hospital to apply for participation as a pharmacy provider.

Information regarding participation requirements and enrollment procedures for the provision of pharmacy services may be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708
Telephone (217) 782-0496

H-205.6 Ambulance Services

The services by an ambulance service which is administratively associated with a hospital, *the cost of which is not included in the hospital's reimbursable cost report,* are not considered by the Department to be hospital services. Such an ambulance service may not bill the Department unless it is enrolled for participation as an ambulance service provider.

Information regarding application and enrollment may be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708

H-205.7 Home Health Services

Home health services are not considered by the Department to be hospital services.

A home health agency which is administratively associated with a hospital and which is certified for participation as a home health agency in the Medicare Program may apply for participation in the provision of home health services to Public Aid recipients.

Information regarding application and enrollment of a home health agency may be obtained from:

Illinois Department of Public Aid
Post Office Box 4034
Springfield, Illinois 62708
Telephone (217) 782-0496

H-206 *Record Requirements*

General requirements pertaining to the maintenance and retention of records are included in Section I, Chapter 100, Topic 111(11).

Participating hospitals must comply with all Federal and State regulations that govern medical records. Department of Public Aid requirements for hospital records pertaining to specific categories of service are included in subsequent topics of this chapter.

The Department regards the maintenance of adequate medical records as essential for the delivery of quality medical care. Medical records are key documents for the audit of payments. Access to these records, by persons designated by the Agency must be permitted. In the absence of proper and complete records, payment may be withheld and/or a recoupment initiated in accordance with provisions indicated in Section I, Chapter 100, Topic 149 and Section III, General Appendix 7A and 7B.

H-210 GENERAL INPATIENT HOSPITAL SERVICES

Inpatient hospitalization is covered only when a recipient's medical need for the services on an inpatient basis is documented in accordance with established utilization review policy and procedures.

General inpatient hospital services are defined by the Department as those services ordinarily provided by licensed general hospitals, other than those identified inpatient services for which the Department has established specific participation requirements. Included in general inpatient services are medical, surgical, pediatric, orthopedic, maternity, intensive care services, etc.

Inpatient services necessary for the treatment of tuberculosis are also considered to be general inpatient services; however, payment for such services can be made by the Department only when they are provided to a recipient who is a resident of a county or a jurisdiction that *does not* levy a special tax for the purpose of providing care for tuberculosis patients. It is the responsibility of the hospital to determine whether such tax levy funds are available to pay for these services prior to submitting a claim to the Department.

Except as specified below, inpatient services for psychiatric care and treatment are not considered to be general inpatient services and may be provided only by hospitals enrolled for category of service "21", Inpatient Hospital Services (Psychiatric), and must be provided in accordance with provisions of Topic H-220.

A hospital not enrolled for inpatient psychiatric services may provide psychiatric care as a general inpatient service only on an *emergency* basis for a maximum period of three (3) days.

Inpatient services provided for the physical rehabilitation of patients during an acute stage of a disabling illness or injury are considered to be general inpatient services. When the acute stage ends and the recipient no longer requires acute hospital care but does require comprehensive inpatient physical rehabilitation services, such services may be provided only by hospitals enrolled for category of service "22", Inpatient Hospital Services (Physical Rehabilitation), and must be provided in accordance with provisions of Topic H-230.

Inpatient services provided to a patient during an acute stage of renal disease are considered general inpatient services; however, when the services are provided for patients involved in Federal or State programs covering end-stage renal disease, they are not considered to be general services. Inpatient services for end-stage renal disease treatment may be provided only by hospitals enrolled for category of service "23", Inpatient Hospital Services (End Stage Renal Disease), and must be provided in accordance with the provisions of Topic H-240.

H-211 *Participation*

Enrollment to participate as a provider of general inpatient hospital services is accomplished as indicated in Topic H-201. There are no additional enrollment requirements to be met for the provision of this category of service.

H-212 *Notification of Hospital Admission*

(Not required at time of MMIS implementation.)

H-213 *Utilization Review*

Before a payment for an inpatient hospital stay can be considered by the Department, utilization review must be completed. Payment can be made only for those services approved by the appropriate utilization review authority.

Utilization review consists of:

1. *Admission Certification*—a review of the medical necessity for inpatient hospital admission.

2. *Continued Stay Review*—a review of the medical necessity for the length of stay as well as for the appropriateness of the level of care.

3. *Medical Care Evaluation Studies*—a medical care review in which an assessment is made of the quality and/or the nature of the utilization of health care services.

The specific Professional Standards Review Organization (PSRO) under contract with the Department of Health, Education and Welfare (HEW) to perform utilization review will perform utilization review of all inpatient hospital services provided to Public Aid recipients.

Until all hospitals have signed a Memorandum of Understanding with a PSRO, the appropriate utilization review authority will be contingent on the existence of a PSRO and the category of inpatient services provided, as specified in subsequent topics in Chapter H-200.

H-213.1 Hospitals With Signed PSRO Memorandum of Understanding

For hospitals operating under signed MOU, utilization review of all inpatient services provided to Public Aid recipients and applicants is the responsibility of the PSRO. It is the responsibility of the PSRO to inform and direct each hospital in its area regarding implementation of the utilization review program.

The PSRO must review the medical necessity of all inpatient hospital services for Public Aid recipients and applicants even though some of the services provided are not covered by the Medical Assistance Program.

H-213.2 Hospitals Without A Signed Memorandum of Understanding With A PSRO

For hospitals without a signed MOU, the Utilization Review Committee (URC) is responsible for utilization review of all inpatient services provided to Public Aid recipients, unless otherwise specified in subsequent topics in Chapter H-200.

H-213.3 Effect of Utilization Review on Payment

The maximum number of days of inpatient hospitalization for which payment can be made by the Department is the number approved by the appropriate utilization review author-

ity. Under ordinary circumstances, only days approved as medically necessary can be allowed for payment and are to be coded 01—acute: certified.

If the hospital anticipates difficulty in arranging placement at the appropriate level of long term care which will be required by a patient following hospital discharge, the Department, as the approval authority, will allow payment, *up to a maximum of three (3) days* in addition to the number of days approved as medically necessary, when the following conditions have been met. The social service department is to contact the local Public Aid office (Nursing Home Service Office in Cook County) three (3) days prior to the anticipated discharge date. If neither the social service office of the hospital nor the local Public Aid office can arrange appropriate placement, the hospital must phone the Department's Special Approval Coordinator to request prior approval of non-acute inpatient days. (See Appendix H-21 which details instructions for requesting special approval and billing procedures for approved "waiting for long term care placement" days.) These days are to be coded 03, 04, or 05, as applicable.

In situations where patients from group care facilities require acute care and a bed is held by the group care facility, no consideration can be given to payment beyond the days approved as medically necessary.

Regardless of the number of days approved by a utilization review authority, payment will not be made by the Department for (1) services that are not covered in the Medical Assistance Program or (2) services that the hospital is not enrolled with the Department to provide. For example:

> Even though a utilization review authority approves a hospitalization for cosmetic surgery, payment will not be made for the hospitalization as it is not a covered service. (See Topic H-204.)

The utilization review authority might approve a hospitalization for end-stage renal disease services even though the hospital is not enrolled with the Department for the provision of this category of service. In such a situation, payment will not be made by the Department.

H-214 *Charges*

Charges are to be made for inpatient hospital services based on calendar days. The day of discharge is not counted. An admission with discharge on the same day is counted as one day. If a recipient is admitted; discharged and re-admitted on the same day, only one day is counted.

The day on which a recipient begins a leave of absence must be treated as the day of discharge or non-certified day and cannot be counted as a covered day unless the patient returns to the hospital prior to midnight of the same day.

The total number of days for which charges can be made cannot exceed the number approved by the appropriate utilization review authority, except as specified in Topic H-213.3.

H-214.1 Recipient With No Medicare Coverage

For recipients who are not eligible for either Medicare Part A or Part B benefits, charges are to be made at the inpatient per diem rate approved by the Department for the hospital.

H-214.11 *Services of Hospital Based Physicians*

If a physician's salary is included in the hospital's cost report for direct patient care, the physician may not bill on a fee-for-service basis.

H-214.12 *Blood Transfusion*

When blood transfusions or packed red cells are administered, hospitals are to encourage replacement of blood used. Any blood replacement must be shown as a credit on a pint-for-pint basis on billings to the Department.

H-214.13 *Services to Newborn Children*

In obstetrical cases, charges associated with delivery and routine newborn nursery care are considered to be incurred by the mother; therefore, only one per diem charge is to be made, in the mother's name, to cover services to both the mother and the newborn child. In instances in which the medical condition of the newborn, as certified by the utilization review authority, necessitates care in other than the newborn nursery (such as in a prenatal center), additional charges may be submitted on a separate inpatient invoice in the child's name; if the child has been determined eligible for assistance.

To expedite application and determination of a newborn child's eligibility for assistance, hospitals may maintain a supply of Form DPA 243, Request for Assistance for Additional Family Member, and provide this form to expectant recipients at the time of admission. (See Appendix H-9 for a facsimile of Form DPA 243.)

H-214.14 *Services Related to Sterilization*

Hysterectomy Performed During Hospital Stay

No payment will be made for a hospital stay when a hysterectomy is performed solely for the purpose of rendering an individual permanently incapable of reproducing, or where, if there is more than one purpose to the procedure, the hysterectomy would not be performed but for the purpose of rendering the individual permanently incapable of reproducing.

Payment for a hospital stay will be made when the stay includes the performance of a medically necessary hysterectomy, which was not performed for the purpose of rendering the woman incapable of reproducing. Payment will be made only if the person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing; and the individual has signed Form DPA 1977, Acknowledgement of Receipt of Hysterectomy Information.

Appendix H-10a is a copy of Form DPA 1977. In order to insure that requirements have been met, the physician who obtained the signed Form DPA 1977, must provide the hospital with a copy for viewing by hospital staff and subsequent attachment to the Form DPA 117 which indicates a hysterectomy was performed.

Sterilization Procedures Other Than A Hysterectomy

Hospital charges for an inpatient stay may be made for services associated with a sterilization procedure, other than a hysterectomy, only when the following standards have been met:

1) the individual has voluntarily given informed consent in accordance with the requirements of the Federal regulations (see "Informed Consent" this topic),

2) the individual is at least 21 years old at the time consent is obtained,

3) the individual is not institutionalized or mentally incompetent, and

4) at least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she have given informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Informed Consent

An individual has given informed consent only if:

1) The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information or advice to the individual to be sterilized:

a) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.

b) A description of available alternative methods of family planning and birth control.

c) Advice that the sterilization procedure is considered to be irreversible.

d) A thorough explanation of the specific sterilization procedure to be performed.

e) A full description of the discomforts and risks that may accompany or follow the performing of that procedure, including an explanation of the type and possible effects of any anesthetic to be used.

f) A full description of the benefits or advantages that may be expected as a result of the sterilization.

g) Advice that the sterilization will not be performed for at least 30 days except in cases of premature deliveries or emergency abdominal surgery as indicated above.

2) Suitable arrangements were made to insure that the information specified in (1)(a) through (g) was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

3) An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

4) The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

5) The consent form requirements specified below were met; and

6) Any additional requirements of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

Informed consent may not be obtained while the individual to be sterilized is:

1) In labor or childbirth;

2) Seeking to obtain or obtaining an abortion; or

3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

In order to insure that consent requirements have been met, the physician who obtained consent for the sterilization must provide the hospital with a copy of the properly completed Form DPA 2189, Consent Form, (R-1-79) for viewing by hospital staff and subsequent attachment to the hospital bill. (Appendix H-11a is a facsimile of Form DPA 2189, Consent Form.)

H-214.15 *Services Related to Termination of Pregnancy*

Charges for an abortion and the associated hospital services are covered services in the Medical Assistance Program only when;

1) The abortion is performed prior to fetal viability and a licensed physician in Illinois certifies in writing that the procedure is "medically necessary". A "medically necessary" abortion is an abortion which is necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in

light of all factors relevant to her health. "Fetal viability" means the point during pregnancy at which, in the professional judgment of a licensed physician in Illinois, a fetus is potentially able to live outside the mother's womb, albeit with artificial aid, such that there is a potentiality for meaningful life, not merely momentary survival; OR,

2) The abortion is perfomed prior to or after fetal viability, and it is certified in writing:

a. by a licensed physician in Illinois, that (s)he has determined that the life of the mother would be endangered if the fetus were carried to term, OR,

b. by two licensed physicians in Illinois, that they have determined that severe and long-lasting physical health damage to the mother would result if the fetus were carried to term; OR,

c. that the abortion is necessary for a victim of rape or incest, when the rape or incest was reported promptly to a law enforcement agency or public health service. (A pregnant woman under 18 is considered to have been the victim of rape, even if she was not forced to have sexual relations.) Note that the required report must be made within 60 days of the incident and must show the name and address of the victim and the date of the incident.. It also must show the name, address and signature of the person making the report and the date of the report.

Excerpts from, B. NATHANSON, ABORTING AMERICA (1979)*

CH. 16
"DEEPER INTO ABORTION"

The news of the Supreme Court's abortion decisions broke on the same January day of 1973 as did word of Lyndon Johnson's death. Curiously, of the two events, I was more interested in ruminating about the former President. I have always been interested in political history, and to me he was a mysterious figure. How could such a consummate politician have allowed himself to get trapped in the Viet Nam quagmire? Of course, I was pleased with Justice Harry Blackmun's abortion decisions, which were an unbelievably sweeping triumph for our cause, far broader than our 1970 victory in New York or the advances since then. I was pleased with Blackmun's *conclusions,* that is. I could not plumb the ethical or medical reasoning that had produced the conclusions. Our final victory had been propped up on a misreading of obstetrics, gynecology, and embryology, and that's a dangerous way to win. But as Vince Lombardi said, "Winning isn't everything—it's the *only* thing."

My relative disinterest in the abortion rulings is explained by the fact that on the day after New Year's of 1973 I plunged into a new phase of my career, as the Chief of Obstetrical Service at Woman's Hospital, St. Luke's Hospital Center, one of the best equipped and busiest departments in Manhattan. I had left the abortion clinic in a state of exhaustion and had just resigned the gynecology directorship at the Hospital for Joint Diseases, planning to avoid any more large projects or administrative positions. But upon my return from the family vacation

* These excerpts are reproduced with the permission of the author.

in Europe, Harold Tovell, the director of the over-all obstetrics-gynecology department, asked me to assume the position at Woman's, and I felt that I simply had to do this, as something of a balance to the medical work I had performed previously. The four years in that post were to have a critical impact upon my thinking about abortion.

One of the first things I did in 1973 was to supervise the establishment of a sophisticated perinatology unit at Woman's, with Tovell laboring valiantly to raise needed funds for fetal electronic heart monitoring machines and other expensive equipment. On of the great underreported medical revolutions of our time is this field of perinatology, the intensive investigation and treatment not only of the newborn baby but of the fetus, this enigmatic organism that, only months before, my charges at the abortion clinic had been extinguishing on a record scale. Oddly, there has been an explosion of knowledge about the fetus during the very years that mass abortion developed.

Over the past fifteen years or so, the pendulum in obstetrics has swung sharply from almost-exclusive concern with the life of the mother (the orientation in which I was trained in my residency) toward strong interest in the health of the fetus. Not that the life of the mother is held in any lower regard, but with the advances in antibiotics, anesthesia technique, and the like, maternal mortality has dropped to an almost irreducible minimum. In many large medical centers the leading causes of maternal death are no longer the old bogeymen of hypertensive disorders, infection, and hemorrhage, but rather cancer or heart disease that coincide with pregnancy, and thrombo-embolic disease. So work on the fetus is the obvious direction for future research. Three English-language journals for this specialization all began publication in 1976: ***Monographs in Fetal Physiology, Reviews in Perinatal Medicine,*** and the best-known,

Perinatal Medicine. In 1977 the citations on biological studies of the fetus consumed more than fifty-one columns of want-ad-size type in the *Index Medicus,* which works out to about 2,000 research articles.

A layman looking at abortion fixes upon the bloodied amorphous remains lying in the gauze bag inside the suction bottle; Right-to-Lifers constantly play upon this squeamishness. No physician, however, could do his work if the sight of human tissue and blood bothered him. Once the operation proceeds, the remains are just tissue to be dispatched to the pathology lab. No, the issue is not the existence of the tissue, but the prior decision that the operation is proper. What began to erode the N.A.R.A.L. dogmas was the daily realization of the "intrauterine patient" that we were treating, tracing, sampling, and observing through electric monitoring or the flickering images on an ultrasonic screen. To a physician, *that* is reality.

This evolution of my thinking will sound incredible to many. I was generally aware of these biological developments during the years of my abortion crusade. Three things happened. First, I reflected again on the older knowledge in perinatology. Second, new data were reported all the time. Third, and most important, I opened myself up to the data. When one is caught up in revolutionary fervor, one simply does not want to hear the other side and filters out evidence without realizing it. Until 1973 I was sold a bill of goods. No—let me be honest—I was selling a bill of goods. I had been terribly disturbed by the injustice and hypocrisy of the '60s, the disparity between rich and poor, East Side and West Side. I had seen the victims of self-abortion and hack abortionists. After the fever of activity had cooled, I found myself reflecting on the seeds of our revolution.

Besides the work at Woman's Hospital, I was influenced by some past reading I had done, and in particular an intriguing novel, *You Shall Know Them,* by the French author Vercors (pseudonym for Jean Bruller). The English translation came

out in 1953 and a copy fell into my hands around 1968. I felt uneasy every time my mind strayed back to this intriguing novel.

Vercors spins a tale about an expedition of anthropologists who visit an island near Australia and stumble across a surviving "missing link" tribe, well hidden in the jungles, that displays some attributes of man and some of beast. To press the issue of whether the creatures, nicknamed "tropis," are human, a journalist on the expedition named Douglas Templemore decides to artificially inseminate a female tropi with his seed. Back in England, Templemore then slays his offspring intentionally, to force a murder trial and settle the question of defining "humanity." On that question rests, among other things, the scheme of an Australian industrialist to train tropis for slave labor in his textile mills. If they are not humans, what differences does it make? An Act of Parliament offers this definition: "Man is distinguished from the Beast by his spirit of religion." This sets up possibilities for satire which Vercors exploits deftly. What haunted me was the point raised by Templemore's lawyer in his summation at the murder trial:

"It did not rest with the tropis to be or not to be members of the human community, but with us to admit them to it. . . . No one is a human being by a right of nature but, on the contrary, before being recognized as such by his fellow man, he must have undergone—in a manner of speaking—an examination, an initiation." Should not the fetus, too, be examined to determine whether it is a member of the human community? Or, equally important, to determine whether it is *not* a member of the human community, and if not, *why* not?

When I cleared out my desk at CRASH on August 26, 1972, before departing for my much-needed vacation, I carefully packed up and removed all my files. I had determined to write up my experience, which I felt was too important to vanish without careful analysis, though I had no idea what I

would write. That summer, Hunter Frost arrived on the scene. He was an old friend who had been amazingly successful in New York advertising. While his star was almost at its zenith he had quit his agency, gone back to New York University to get a master's degree in English, and moved his family to Colorado to teach at a prestigious prep school, the Fountain Valley School. Hunter was a thin, intense man with a most engaging manner, and I had always been able to confide in him, perhaps more so than with anyone else I knew.

We began to talk about abortion. I took him to the clinic on several occasions till he got to know everyone, and he interviewed numbers of people with an eye to doing a book on the history and functioning of CRASH. But Pyle and I were barely speaking by then, and without her cooperation he felt it would be too difficult to do the book. Instead, we spent long hot evenings discussing my troubled feelings about abortion. It was the first time I had really opened up my own thoughts and discussed the issue in depth with anyone. I tried to sort out my ideas, to formulate some moral posture on the entire subject. We drafted a few statements, diagrams, and declarations, but in the end I knew that something was lacking. Through those ventilating sessions with Hunter it became increasingly clear that I—Bernard Nathanson, a founding father of N.A.R.A.L. and operator of the largest abortion clinic in the world—was entertaining serious doubts now about abortion. The realization was a bit frightening. The mental landscape was incomplete. I knew that I had to bring to the matter something more profound than a formless, splanchnic aversion. Hunter returned to Colorado in late August only half-humorously suggesting that I was suffering some undiagnosable equivalent of the *crise de foie,* only the target organ was not the liver but something in the region of the conscience. We had set some things to paper, but only the black. The white had yet to be formulated. 'Chiaroscuro" was then the working title of my nascent article.

Were those germinating seeds of doubt evident to my clinic staff and board, to the abortion activists? At the annual N.A.R.A.L. meeting that fall some were too polite to ask about my resignation from the clinic, evidently aware that it was a touchy subject with me, like a nasty divorce. To those who inquired, my stock answer was that I had exhausted myself. I told them of my desire to return to the comparative serenity of private practice. In addition, my group of junior associates had broken up that summer, so I was alone in my practice and no longer had partners to cover for me while I was engaged in other areas.

During the spring of 1973 I began reformulating my article, newly influenced by perinatology. I had by then decided two things: first, that we had to continue offering abortions without restriction, and second, that everyone ought to be counseled to think about abortion more carefully. That following summer Hunter Frost visited again, and we spent long hours batting arguments back and forth as he helped me with the phrasing of the evolving article. When the piece was completed I sent a copy to Larry Lader at N.A.R.A.L. He made no objections, but asked me to hold it a couple of months because "the climate is not right." Translated, that meant that once again there was some sort of intramural fight within N.A.R.A.L. At summer's end I submitted my manuscript to the *New England Journal of Medicine,* in which I had reported on our clinic's safety record with the first 26,000 patients. The editor, Franz J. Ingelfinger, took the unusual step of phoning me to accept the piece for publication as soon as possible. He asked me to add an introductory section, and the article appeared as follows in the "Sounding Board" section of the November 28, 1974, issue:

Deeper into Abortion

In early 1969 I and a group of equally concerned and indignant citizens who had been outspoken on the subject of legalized abortion organized a political action unit

known as NARAL—then standing for National Association for Repeal of Abortion Laws, now known as the National Abortion Rights Action League. We were outspokenly militant on this matter and enlisted the women's movement and the Protestant clergy into our ranks. We used every device available to political-action groups such as pamphleteering, public demonstrations, exploitation of the media, and lobbying in the appropriate legislative chambers. In late 1969 we mounted a demonstration outside one of the major university hospitals in New York City that had refused to perform even therapeutic abortions. My wife was on that picket line, and my three-year-old son proudly carried a placard urging legalized abortion for all. Largely as a result of the efforts of this and a few similar groups, the monumental New York State Abortion Statute of 1970 was passed and signed into law by Governor Nelson Rockefeller. Our next goal was to assure ourselves that low cost, safe, and humane abortions were available to all, and to that end we established the Center for Reproductive and Sexual Health, which was the first —and largest—abortion clinic in the Western world. Its record was detailed in these pages in February 1972.

Some time ago—after a tenure of a year and a half—I resigned as director of the Center for Reproductive and Sexual Health. The Center had performed 60,000 abortions with no maternal deaths—an outstanding record of which we are proud. However, I am deeply troubled by my own increasing certainty that I had in fact presided over 60,000 deaths.

There is no longer serious doubt in my mind that human life exists within the womb from the very onset of pregnancy, despite the fact that the nature of the intrauterine life has been the subject of considerable dispute in the past. Electrocardiographic evidence of heart function has been established in embryos as early as six weeks. Electroencephalographic recordings of human brain activity have been noted in embryos at eight weeks. Our capacity to measure signs of life is daily becoming more sophisticated, and as time goes by, we will doubtless be able to isolate life signs at earlier and earlier stages in fetal development.

The Harvard Criteria for the pronouncement of death assert that if the subject is unresponsive to external stimuli (e.g., pain), if the deep reflexes are absent, if there are no spontaneous movements or respiratory efforts, if the electroencephalogram reveals no activity of the brain, one may conclude that the patient is dead. If any or all of these criteria are absent—and the fetus does respond to pain, makes respiratory efforts, moves spontaneously, and has electroencephalographic activity—life must be present.

To those who cry that nothing can be human life that cannot exist independently, I ask if the patient totally dependent for his life on treatments by the artificial kidney twice weekly is alive? Is the person with chronic cardiac disease, solely dependent for his life on the tiny batteries on his pacemaker, alive? Would my life be safe in this city without my eyeglasses?

Life is an interdependent phenomenon for us all. It is a continuous spectrum that begins in utero and ends at death—the bans of the spectrum are designated by words such as fetus, infant, child, adolescent, and adult.

We must courageously face the fact—finally—that human life of a special order is being taken. And since the vast majority of pregnancies are carried successfully to term, abortion must be seen as the interruption of a process that would otherwise have produced a citizen of the world. Denial of this reality is the crassest kind of moral evasiveness.

The fierce militants of the Woman's Liberation evade this issue and assert that the woman's right to bear or not to bear children is her absolute right. On the other hand the ferocious Right-to-Life legions proclaim no rights for the woman and absolute rights for the fetus.

But these "rights" that are held to be so obvious and so undeniable are highly suspect. None of us have "rights" that go beyond the inter-related life that is our common heritage on this planet. Our "rights" exist only because others around us care enough about us to see to it that we have them. They have no other source. They result from no other cause.

Somewhere in the vast philosophic plateau between the two implacably opposed camps—past the slogans, past the pamphlets, past even the demonstrations and the legislative threats—lies the infinitely agonizing truth. We are taking life, and the deliberate taking of life, even of a special order and under special circumstances, is an inexpressibly serious matter.

Somehow, we must not deny the pervasive sense of loss that should accompany abortion and its most unfortunate interruption of life. We must not coarsen our sensitivities through common practice and brute denial.

I offer no panacea. Certainly, the medical profession itself cannot shoulder the burden of this matter. The phrase "between a woman and her physician" is an empty one since the physician is only the instrument of her decision, and has no special knowledge of the moral dilemma or the ethical agony involved in the decision. Furthermore, there are seldom any purely medical indications for abortion. The decision is the most serious responsibility a woman can experience in her lifetime, and at present it is hers alone.

Can there be no help for the pregnant woman bearing the incalculable weight of this moral tension? Perhaps we could make available to her—though it should by no means be mandatory—a consultative body of unique design, much like Saint-Simon's Council of Newton. To meet the new moral challenges of the abortion decision, we may very well need specialists, some of new kinds, to serve on such a body—a psychohistorian, a human ecologist, a medical philosopher, an urbanologist-clergyman. The counseling that such a body could offer a pregnant woman would be designed to bring the whole sweep of human experience to bear on the decision—not just the narrow partisanship of committed young women who have had abortions and who typically staff the counselor ranks of hospitals and clinics now.

My concern is increased by the fact that the sloganeers, with their righteous pontifications and their undisguised desires to assert power over others, have polarized American reactions into dimly understood but tenaciously held positions. The din that has arisen in our land has already created an atmosphere in which it is difficult, if not impossible, for the individual to see the issues clearly and to reach an understanding free from the taint of the last shibboleth that was screamed in her ear.

Our sense of values has always placed the greatest importance upon the value of life itself. With a completely permissive legal climate for abortion (and I believe that we must have such a climate—that abortion must be unregulated by law) there is a danger that society will lose a certain moral tension that has been a vital part of its fabric. In pursuing a course of unlimited and uncontrolled abortion over future years, we must not permit ourselves to sink to a debased level of utilitarian semiconsciousness.

I plead for an honest, clear-eyed consideration of the abortion dilemma—an end to blind polarity. We have had

enough screaming placards and mindless marches. The issue is human life, and it deserves the reverent stillness and ineffably grave thought appropriate to it.

We must work together to create a moral climate rich enough to provide for abortion, but sensitive enough to life to accommodate a profound sense of loss.

* * * * *

During the years after "Deeper," I continued to ponder it all. It was apparent that the public issue was not going to die. Justice Blackmun had inflamed it with his decisions rather than putting it to rest. All we had were the coathanger pins of the pro-choicers and the roses and bottled fetuses of the pro-lifers. Where was the argumentation from a religiously neutral, biologically informed viewpoint? Medical ignorance on the subject abounded, and I had had an enormous mass of clinical experience of perhaps 75,000 abortions, including ones I had supervised at the clinic, had indirect hospital knowledge of, or had performed myself. I decided that I must start over from the beginning, compile and examine all my life experiences and all the pros and cons in the debate, and offer my conclusions, going deeper yet into abortion.

CH. 24

A LIFE FOR A LIFE

In morality, life can only be equated with life, not with convenience or sociology or politics or economics or poverty; not even (in the truly hard cases) with the burden of responsibility for a seriously retarded or handicapped child, or of bearing a child resulting from rape or infidelity. In arguing an issue of life, one can only invoke issues of life to counterbalance it. Liberals who are pro-abortion immediately recognize that, in capital punishment, only murder would justify even *considering* the intentional taking of life. We do not execute car thieves.

Those of us in the pro-abortion crusade used two special "mother's life" arguments. The first was the "coathanger" plea. Not only is this a self-inflicted threat to life, but it is one that, as I have stated, would be reduced to the vanishing point by recent medical developments if abortion were again made illegal.

The other case we cited was the threat that if a particular woman were not allowed to abort, she would kill herself. In our rush to get hospital permissions, as I have recounted, many psychiatrists were willing to enlarge upon such dangers, but the clinical fact is that suicide virtually never results from pregnancy in and of itself. If pregnant women commit suicide, it is because of issues other than the pregnancy. As it happens, pregnant women kill themselves noticeably less often than do non-pregnant women. It may even be that pregnancy is a protection *against* suicide. A former New York City medical examiner once stated that he had never in his career seen a single case of a pregnant woman who took her own life. Even the brief of pro-abortion plaintiffs in the federal *McRae* v. *Califano* case admits, "Not one of the maternal mortality studies lists a single case of maternal death from suicide."

* * * * *

The abortion policy that I have finally settled upon distinguishes between medical abortions (permissible) and those that are not medically indicated (not permissible). We must, in applying this principle, reject the sloppy usage of "medical indications" that I was a party to in the 60's covering all manner of psychiatric, social, or eugenic perplexities, or simply the wish of the mother. On the other hand, it must be more flexible and medically sophisticated than anything that I have seen emanating from the Right-to-Life forces. The list of indications *cannot be etched in stone;* it varies by medical knowledge. There was a time when tuberculosis was correctly considered to be an indication; now it is not. On the other hand, medical research has identified indications that formerly

were unknown. Some specific indications might apply with one pregnancy and not with another.

As a point of departure, let us take the so-called "Hyde Amendment" as it was reshaped and finally passed by the U.S. Congress in December 1977. This law had to do only with what cases should come under Medicaid poverty funding, but in effect it expressed what the people's representatives considered to be generally acceptable grounds for abortion. One clause covered promptly reported rape and incest (not a medical indication), and the rest of the bill specified those cases:

1. ". . . where the life of the mother would be endangered if the fetus were carried to term." (The lethal ectopic pregnancy is listed in a separate section.)

2. ". . . where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term," as determined by two physicians.

As a member of the American College of Legal Medicine, I have some familiarity with the ways in which legal language must accommodate medical imponderables, and I must state that Congress here was off the mark, as the Supreme Court had been previously. First, the wording is unacceptable vague. To what *extent* must life be endangered? The danger should be compared with the statistical average in routine, uncomplicated pregnancy, since there is a theoretical statistical risk in *any* pregnancy (or, for that matter, in any auto trip). The current rule of thumb is that fewer than twenty of 100,000 pregnant women will die. This figure should not be fixed by statute since it will continue to decline, but the law should state that the latest data of biostatisticians be used to define which medical problems produce a demonstrable increment of death. To me, a statistically significant increment over the usual risk of pregnancy constitutes an endangerment of life that justifies abortion. And it must be the pregnancy itself that materially

contributes to the condition; abortion makes no sense in an endangered woman if the elimination of alpha has no bearing on her prospects.

What constitutes "severe and long-lasting" health damage short of imminent danger to death? This is not medically precise. Most health conditions that are cited by pro-abortionists are temporary and can be treated. There must, rather, be a reasonable probability that the co-existence of pregnancy will materially and significantly shorten the mother's life-span. This rule cannot be quantified, but it is not difficult to determine medically in a particular case. Again, the pregnancy itself must be determined to be the cause of the life-shortening.

So I am proposing two "life" criteria: pregnancy that raises the risk of imminent death *now*, and pregnancy that will hasten death *then*. My proposal would radically reduce the number of legal abortions to perhaps several thousand a year. Even under the fuzzy Hyde language, between February 14 and December 31, 1978, there was a reported 99 per cent decrease nationally in Medicaid-funded abortions from a previous total of about 250,000 per year. Only 385 were approved on health danger, 1,857 for life endangerment, and 61 for rape/incest. This shows the degree to which abortions are being performed on other than medical grounds. In practice, it is not possible to spell out every probable element in medical practice, and each case of a particular disease will vary. What we need—and can develop—is a workable ethical standard.

Each mother must be considered individually. Some might suppose that because the death rate of women in pregnancy is statistically higher after age thirty-five or age forty, age alone would justify abortion under my proposal. This is a misunderstanding. It is the specific medical problems such as those to be discussed below that increase with age and that kill the women, not the age as such. Doctors treat patients and diseases, not age groups. Sometimes the very young teen-age mother is set apart

into a high-risk category, but this is a social problem rather than a strictly medical one. The statistically higher rate of difficult pregnancy is not due to the very young mothers' age, but to the fact that they do not consult physicians readily or often enough.

My policy would exclude a variety of maladies in pregnancy that some doctors have cited as "medical indications," but which are treatable and not life-endangering: varicose veins, myoma (benign tumor of the uterus), urinary tract infections, an expected necessity for Caesarean section, anemia and other forms of malnutrition, hyperemesis (excessive vomiting), peptic ulcer, or cystitis. In cases of multiple sclerosis, the symptoms are exaggerated in pregnancy, but life is not shortened as such. In the "possible" category—justifiable with certain patients—might be colitis, respiratory maladies such as bronchectasis, and some chronic degenerative diseases of the nervous system.

Some other typical indications:

1. *Diabetes*—This disease is life-threatening and carries other health hazards, and it usually worsens in late pregnancy. But there is no firm evidence that pregnancy in and of itself shortens the diabetic mother's life-span, so it probably is not an indication. Diabetes *is* a very difficult problem for alpha, which raises the eugenic issue. At the parents' option, this may require birth control or sterilization.

2. *Obesity*—Using the guideline of 250 pounds (some obstetricians say 300), this condition produces a higher mortality rate in pregnancy because it is difficult to treat the patient, delivery is more problematic, and other medical problems result. The increased threat may be such that abortion would have to be considered.

3. *Cancer*—(Other than removal of a cancerous uterus, which even the Vatican accepts.) It is often stated that cancer is a medical indication. Cancers other than

those of the breast and the female genital tract are probably not affected by pregnancy. Even in these cases, cancer is not necessarily an indication, since certain cases are not worsened by pregnancy. In breast cancer, the danger often can be determined through a new test for whether the cancer is estrogen-receptor positive. If it is, pregnancy probably will inflame the condition and may be lethal; abortion is justified.

4. *Chronic heart or kidney disease*—Unlike with diabetes, here there is a direct link between the pregnancy and the increased strain that is put on the diseased heart or kidneys, so both are medical indications. A Right-to-Life advocate might argue that there are options: One could perform open-heart surgery or a kidney transplant, or use kidney dialysis, and avoid the need to abort. In my view, these remedies must not be required because the mortality rate of the corrective procedure is noticeably higher than that of the abortion, most certainly with surgery and possibly with dialysis. On the other hand, I would reject the case where a mother can cope while resting during pregnancy but endangers her heart if she does housework. In this case, housekeeping help should be provided, not an abortion.

5. *Sickle-cell anemia*—(As opposed to common anemia.) The rare S-C form of sickle-cell may be lethal in pregnancy but even the common S-S form is risky; either is an indication.

6. *Intrauterine device*—The IUD is, of course, supposed to prevent pregnancy, but in certain cases the woman becomes pregnant anyway with the device still present in the womb. It must be removed as soon as pregnancy is diagnosed. However, if by mistake the IUD is left in until pregnancy has so advanced that it cannot be removed, there is no question that abortion is always

permissible. Even though some IUD pregnancies would produce healthy children without incident, the obstetrician never knows which cases. An infection that an IUD might produce if left in the uterus is so deadly and spreads so rapidly that the device is a continual threat to the mother's life.

7. *Hypertension*—Elevated blood pressure by itself is occasionally a threat to life. About one in three hypertensive pregnant women also will develop pre-eclampsia or its advanced state, eclampsia, later on in the pregnancy. (Pre-eclampsia is a syndrome with constricted small arteries, particularly in the uterus, eyes, liver, and brain, the latter possibly producing a stroke. Eclampsia is an advanced state of the syndrome, with convulsions. We do not know the cause of this disease and therapy is difficult.) Pending better predictability of which cases of hypertension will lead to pre-eclampsia/eclampsia, or improved therapy for this disease, advanced hypertensive disease should be grounds for abortion.

8. *Thrombo-embolic disease*—A woman may have a blood clot or an embolism (a clot that breaks off from its site) and recover from the disease, but if pregnancy later occurs there is a much higher risk of a rapid and lethal clot. Thus, this may be an indication. Superficial phlebitis (inflammation of a small surface vein) is not an indication, but deep-vein phlebitis is quite dangerous. Fortunately, this is a case where drug treatment is feasible and abortion is not necessary. The physician is able to prescribe heparin, a drug that does not cross the placenta and therefore does not endanger alpha, either.

This is an incomplete list of the major examples, assuredly not an exhaustive catalogue, but it should serve to illustrate how the above principles would apply.

Along with these proposals, I would like to propose that the anti-abortion legions declare a moratorium on their marches at hospitals and clinics and their intimidation of women patients long enough to ponder these questions that obstetricians face daily and to notify the rest of us which abortion indications *they* are willing to endorse.

Back in January of 1975 when Ruth Proskauer Smith was deciding whether I should be excommunicated from N.A.R.A.L., she sent me an inquisition-by-mail. One of her seven questions demanded of me, "Does your expressed anguish at having 'presided over 60,000 deaths' imply that you plan to make changes in your own medical practice?"

The answer in 1975 was that it made not the slightest difference. I was willing to perform an abortion for any patient, at any stage prior to "viability," for any reason. I considered the physician to be merely the instrument of the woman's desires in the matter of abortion.

Given the rather strict list of abortion justifications that I have just presented, the reader of this book will likely be asking Ruth Smith's question all over again. Do I (medically) practice what I preach?

About a year after resigning from N.A.R.A.L., I started feeling viscerally that I did not like doing abortions. Still, I did them. Sometime toward the end of 1976 this changed. One day, I cannot now recall the patient or the circumstances, I decided that I would perform no more of the grotesque "second trimester" abortions except on strict medical grounds—even for longtime patients in my private practice. Around the same time I also began refusing to do elective abortions at *any* stage for new patients who came to me. I would tell them, "I'm sorry, I don't do abortions any more, for ethical reasons, but my associate Dr.———— will do it for you. I will be on hand in the operating room during the procedure." And so quietly, without fanfare or notice, I was out of the elective (i.e., non-medical)

abortion business, except for "first-trimester" abortions done for established patients of mine.

My phased withdrawal went ahead in December of 1977, while I was doing the preliminary reflections toward this book. For the first time, I refused to do an early abortion for a longtime patient, citing the same ethical objections that I routinely used with new patients. She was not at all happy at this news and wanted me to perform it anyway. Quietly, I checked out my legal situation with my lawyer, regarding the question of "medical abandonment" of a patient. The lawyer advised me that this was a new legal issue, particularly because I had not changed my views as a result of religious conversion, but that there was little risk. He said I should be on acceptable legal footing if I referred her to an obstetrician-gynecologist of equal competence. In January 1978 I went ahead with the abortion anyway. She was still insistent and my own thinking had not crystallized.

During 1978 I continued refusing to do non-medical abortions for all patients, but ended up performing several anyway. In one case, I did not even raise the problem and, in fact, shielded my reluctance because, in my best judgment, the patient was unusually dependent upon me and I knew my refusal would have been interpreted as a rejection of her, probably throwing her into panic. Obstetrics and gynecology is so sensitive a field that it is probably the closest specialty there is to psychiatry. A doctor bears a heavy ethical burden in the case of a patient with an unusual degree of dependence upon him.

And so as this book went to the publishers I was caught in the paradox of considering elective abortion to be an unjust taking of human life and yet performing one now and then when I was unable to avoid it. Perhaps in the future I will refuse regardless of the circumstances.

There are 75,000 abortions in my past medical career, those performed under my administration or that I supervised in a teaching capacity, and the 1,500 that I have performed myself. The vast majority of these fell short of my present standard that only a mother's life, interpreted with appropriate medical sophistication, can justify destroying the life of this being in inner space which is becoming better known to us with each passing year. I now regret this loss of life. I thought the abortions were right at the time; revolutionary ethics are often unrecognizable at some future, more serene date. The errors of history are not recoverable, the lives cannot be retrieved. One can only pledge to adhere to an ethical course in the future.

FOR ARGUMENT

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

JEFFREY C. MILLER, Acting Director, Illinois Department of Public Aid,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation, and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

REPLY BRIEF OF APPELLANT MILLER

WILLIAM J. SCOTT,
Attorney General of Illinois

Attorney for Appellant.

WILLIAM A. WENZEL, III,
JAMES C. O'CONNELL,
ELLEN P. BREWIN,
Special Assistant Attorneys General
130 North Franklin Street, Suite 300
Chicago, Illinois 60606
(312) 793-2380
Of Counsel

Printed by the Authority of the State of Illinois—4-80-100

INDEX

TABLE OF AUTHORITIES

Cases

Constitution, Statutes and Regulations

Miscellaneous Authorities

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

JEFFREY C. MILLER, Acting Director, Illinois Department of Public Aid,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., on their own behalf and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation, and JANE DOE, on her own behalf and on behalf of all others similarly situated,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS,
EASTERN DIVISION

REPLY BRIEF OF APPELLANT MILLER

I.

THE CONDITIONS FOR REVIEW OF THE CONSTITUTIONALITY OF THE HYDE AMENDMENT AND PRIOR STATUTORY RULINGS OF THE SEVENTH CIRCUIT AND THE DISTRICT COURT HAVE BEEN MET IN THIS CASE

A.

The Hyde Amendment Was At Issue In The Proceedings Below.

Plaintiffs and the United States assert that the District Court was without jurisdiction over the validity of the Hyde Amendment because there was no "case or controversy" as mandated by Article III, § 2 of the Constitution. This position ignores the fact that all defendants placed the Hyde Amendment at issue by moving for summary judgment pursuant to FED.R.CIV.P. 56 based upon the constitutionality of the federal statute. Since the defendants placed the Hyde Amendment at issue by their pleadings, it is clear that the argument of the plaintiffs and the United States rests on the proposition that there can be no "case or controversy" over an issue unless it is expressly raised as a part of plaintiffs' cause of action within the parameters of the complaint.

Article III, however, confers jurisdiction over "cases" and not merely claims or causes of action. *See, Aldinger* v. *Howard,* 427 U.S. 1, 13-14 (1976); *cf., United States* v. *Memphis Cotton Oil Co.,* 288 U.S. 62, 67-68 (1933); *Baltimore S.S. Co.* v. *Phillips,* 274 U.S. 316, 321 (1977). The inquiry as to whether a claim for relief qualifies as a case "arising under . . . the Laws of the United States" is distinct from the question of whether various "claims" constitute a "case" for jurisdictional purposes. *United Mine Workers of America* v. *Gibbs,* 383 U.S. 715, 725 n.12 (1966). Indeed, this Court has recognized that the boundaries of a constitutional "case" are not limited to the face of plaintiffs' complaint. *See, Continental T.V., Inc.,* v. *GTE Sylvania, Inc.* 433 U.S. 36, 40 (1977); *Beacon Theatres, Inc.* v. *Westover,* 359 U.S. 500, 502-03 (1959). Acceptance of plaintiffs' argument would effectively preclude a defendant from ever raising affirmative legal defenses and would prevent a district court from hearing compulsory counterclaims, FED.R.CIV.P. 13(a), or cross claims, FED.R.CIV.P. 13(g). In the absence of Congressional intent to the contrary, this Court should not sanction a rule which limits the jurisdiction of

federal courts to the express claims and relief sought within the four corners of plaintiffs' complaint. *See, Owen Equipment & Erection Co.* v. *Kroger,* 437 U.S. 365 (1978); *Aldinger* v. *Howard,* 427 U.S. 1 (1976); *Kahn* v. *International Paper Co.,* 414 U.S. 291 (1973).

Plaintiffs and the United States also ignore the fact that any claim for relief under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq* regarding funding for abortions necessarily required the court to interpret the intent of Congress in enacting the Hyde Amendment. As was stated in another setting, "Congress did not intend to confine the jurisdiction of federal courts so inflexibly that they are unable to protect legal rights or effectively to resolve an entire, logically entwined lawsuit." *Owen Equipment & Erection Co.* v. *Kroger, supra,* 437 U.S. at 377. Because of the federal funding restrictions present in the Hyde Amendment, on the one hand, and federal funding obligations present in Title XIX, *see,* 42 U.S.C. § 1396b(a) & § 1396d(b), on the other hand, the validity of the state law at issue here is inextricably and "logically entwined" with that of the Hyde Amendment.

Plaintiffs, however, rely on *Moore* v. *Charlotte-Mecklenburg Board of Education,* 402 U.S. 47 (1971) and suggest that because "[t]he United States and Illinois agree that the Hyde Amendment is constitutional" there is no Article III case or controversy. Brief for Appellees, p. 30. Plaintiffs ignore the fact that the infirmity found by this Court in *Moore* was that "both litigants desire[d] precisely the same result", 402 U.S. at 48. Here, there is an essential antagonism between plaintiffs and the state defendants based upon the logical relationship between P.A. 80-1091 and Hyde. Moreover, the interests of the United States and the State are, in part, adverse. After the District Court had declared both the Hyde Amendment and P.A. 80-1091 unconstitutional, Defendant Quern filed a motion to require federal reimbursement for all "medically necessary" abortions which were required to be funded under

the Final Judgment Order. The United States flatly opposed this motion, and refused to pay for any non-Hyde Amendment abortions. To this day, Illinois has received no federal financial reimbursement for non-Hyde Amendment abortions it has funded as a consequence of the April 30, 1979 Judgment Order. Hence, the requisite "adverseness" regarding the Hyde Amendment is present.[1]

B.

The Court May Review All Prior Statutory Rulings Below.

Moreover, by finding that the Hyde Amendment is properly before this Court within this case, the Court, as a result of its rulings here and in *Harris* v. *McRae,* No. 79-1268, will be in a position to promote judicial economy by resolving the entire spectrum of Title XIX and Hyde Amendment abortion-related controversies presented in both cases. This includes clarification of the Seventh Circuit's statutory analysis which prefaced its holding that the Hyde Amendment constituted a substantive modification of Title XIX. Defendant's basis for seeking review of the Seventh Circuit's ruling still primarily rests upon his contention that an appeal under 28 U.S.C. § 1252 brings up the "whole case", Brief of Appellant Miller, pp. 25-31, and particularly upon the observation by this Court that its power of review where jurisdictional requirements are otherwise satisfied extends to "all other questions arising on the record, including those passed upon by the circuit court of appeals." *Union Trust Co.* v. *Westhus,* 228 U.S. 519, 522 (1913). Should the Court, however, deem it inappropriate to rely on the "whole case" concept, Defendant Miller submits

[1] Equally significant, is the purported reversal of long-standing HEW interpretation of Title XIX requirements by the present Secretary of HEW "promulgated" for the first time in the Brief of the United States, pp. 43-44, n.23. This interpretation regarding the concept of "medical necessity" has evoked a heated controversy between the states and HEW. *See* discussion, Part II, *infra.*

that the Judgment Order of April 30, 1979 [Jurisdictional Statement, A43-A48], which is without question subject to court review, has incorporated the prior rulings of the Seventh Circuit and the District Court on the statutory issues. Thus, the Final Judgment Order provides, *inter alia:* "the District Court's previous May 15, 1978 Judgment and its June 13, 1978 Judgment, *as modified by this February 15, 1979 Order, remain in force;*" (emphasis added) p. A43; and " 'Illinois' restrictive abortion funding policy' means the policy Illinois adopted pursuant to P.A. 80-1091, ILL.REV.STAT.SUPP. (1977), ch. 23, §§ 5-5, 6-1, 7-1, *as modified by the District Court Order of February 15, 1979"* (emphasis added), p. A44. See, ¶ 4(a)(i) of the Judgment Order which employs the term "Illinois' restrictive abortion funding policy" and grants partial summary judgment to the plaintiffs by invalidating P.A. 80-1091. *Id.* As incorporated, the earlier injunction order has merged with the Final Judgment Order and is accordingly fully reviewable. Defendant Miller's fourth question presented in his Jurisdictional Statement reflects his intention to seek review of the statutory issues and thus all the conditions for such review have been satisfied.

Since there is still a controversy regarding the proper interpretation of Title XIX without regard to the Hyde Amendment, this Court should resolve that question.[2]

[2] *Cf., Quern* v. *Mandley,* 436 U.S. 725 (1978), 98 S.Ct. 2068, 2074 n.7: "State's decision to withdraw voluntarily from the § 406(e) program in no way mooted the Court of Appeals' prior determination that the program was being operated in violation of federal law. . . . [Defendant's decision to withdraw] could not operate to deprive the successful plaintiffs, and indeed the public, of a final and binding determination of the legality of the old practice. *United States* v. *W. T. Grant Co., supra,* 345 U.S. at 632, 73 S.Ct., at 897."

II.

CONTRARY TO THE INTERPRETATION OF THE CURRENT SECRETARY OF HEALTH, EDUCATION AND WELFARE, TITLE XIX CONTAINS NO "MEDICAL NECESSITY" LIMITATION ON STATE DISCRETION OVER THE SCOPE AND EXTENT OF MEDICAL ASSISTANCE BENEFITS.

In a footnote which warrants the Court's most careful scrutiny, the Secretary, through the Solicitor General, makes the following statement:

> In establishing the Medicaid program in 1965, Congress required participating states to pay, at minimum, for services in five mandatory categories, including inpatient and outpatient hospital services and physicians' services . . . [citations omitted]. In light of the importance Congress attached to the provision of services within the mandatory categories . . . [citations omitted], *the Secretary of HEW has interpreted the Medicaid Act to require participating states to fund medically necessary care falling within those categories.* In particular, an HEW regulation precludes denial or reduction of payments, for medically necessary services falling within any of the five mandatory categories, solely on the basis of "diagnosis, type of illness, or condition." 42 C.F.R. 440.230(c)(1). *The statute and regulation would be violated if a state were to single out medically necessary abortions for exclusion from coverage,* because such action by a participating state would constitute a denial of payments based solely on diagnosis (*i.e.,* that an abortion is medically necessary) and condition (*i.e.,* pregnancy)
>
> *The statutory requirement that each state Medicaid plan "include reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan" (42 U.S.C. 1396a(a)(17)(A)) does not authorize an otherwise prohibited exclusion of therapeutic abortions from coverage.* That statutory provision . . . was not intended to permit states to refuse payments on the basis of the kind of condition for which treatment is needed or the kind of medically necessary services within any of the five mandatory categories for which benefits are sought . . .
>
> *Recognizing that the stated purpose of the Act is to provide "necessary medical services" (42 U.S.C. 1396) . . . [the Secretary has not] authorized participating states to eliminate coverage of a particular kind of medically necessary care.* (Emphasis added)

Brief for the United States at 43-44, n. 23.

Illinois and the amici states argued in their initial briefs that Title XIX on its face imposes no such requirement on participating states and that the legislative history, when read in its historical context, discloses no such intention on the part of the Congress. Director Miller submits that appellees and the Secretary's arguments to the contrary amount to an heroic effort to resuscitate an analysis which expired with the First Circuit's opinion in *Preterm Inc.* v. *Dukakis,* 591 F.2d 121 (1st Cir. 1979), *cert. denied, sub nom., Preterm, Inc.* v. *King,* ____ U.S. ____, 99 S. Ct. 2181 (1979). Illinois' concern in this portion of its reply is to point out to the Court that the Secretary's has *in fact* approved numerous state plan provisions which conflict with the representations and interpretations contained in footnote 23. Thus, her views, erroneous as a matter of law for the reasons previously discussed, Brief of Appellant Miller, pp. 45-55, are not entitled to the deference this Court has afforded them in previous cases. *E.g., Beal* v. *Doe,* 432 U.S. 438, 447 (1977) (deference to agency construction); *New York Department of Social Services* v. *Dublino,* 413 U.S. 405, 420-21 (1973) (established and consistent policy entitled to deference absent "compelling indications that it is wrong . . ."). Indeed, it is HEW's plan approval actions, and not its litigation justifications as voiced by the Solicitor General, which should control. *See Quern* v. *Mandley,* 436 U.S. 725, 738 (1978) ("by approving state plans that cover [certain benefits] HEW has expressed its view that such items are properly included [in state a plan] . . ."); *Citizens to Preserve Overton*

Park v. *Volpe,* 401 U.S. 402, 419 (1971) (criticizing "litigation affidavits" as "merely *post hoc* rationalizations" inadequate to determines the factual basis of agency action).

Title XIX requires the Secretary to "approve any plan which fulfills the conditions specified in subsection (a) of this section . . ." 42 U.S.C. § 1396a (1976). Pursuant to Congress's directive, and despite the Secretary's post hoc averments to the contrary in footnote 23, the Secretary as of March, 1980, had approved fourteen state plan amendments limiting benefits for medically necessary abortion services.[3] For examples of such state plan amendment approvals, see reproduced portions of the Kansas plan, 37a-38a, *infra* and the Kentucky plan, 41a *infra.*

In addition to approving state plan restrictions on abortion benefits, the Secretary has also approved a variety of other specific limitations on the reimbursement of costs related to the provision of health care services falling within the first five subdivisions of 42 U.S.C. § 1396d(a)(1)-(5) (1976). For example, Arkansas limits outpatient visits to twelve per calendar year; Florida limits inpatient hospital services to forty-five days and outpatient services to a maximum of $500 per patient per fiscal year; Georgia will not reimburse the expense of private duty nurses and limits outpatient visits to one per month

[3] Based upon a review of official plan documents currently on file in the offices of the Health Care Financing Administration, Department of Health, Education and Welfare, Woodlawn, Maryland, the following states have approved state plan amendments limiting abortion funding; Connecticut (effective September 1, 1977); Kansas (effective October 1, 1978); Kentucky (effective January 1, 1979); Louisiana (effective April 1, 1978); Maryland (effective January 16, 1980); Minnesota (effective September 18, 1978); Missouri (effective August 2, 1977); Nebraska (effective December 11, 1978); North Carolina (effective date unavailable); Rhode Island (effective October 1, 1978); Vermont (effective January 1, 1980); Virginia (effective July 1, 1979); Wisconsin (effective September 30, 1978); and Wyoming (effective October 1, 1979).

with certain exceptions; Hawaii limits inpatient psychiatric care (but not other forms of inpatient care) to eighteen days; Kansas limits computerized axial tomography (CT scanning) to head scans (other states reimburse the cost of body scans as well); Louisiana limits outpatient visits to three per year with "no provisions for any additional visits"; Nevada limits physician services to two office visits and two therapeutic injections per month; the Northern Mariana Islands does not reimburse occupational therapy costs incurred in an outpatient department; and Puerto Rico and the Virgin Islands reimburse the cost of services only if they are provided in public facilities or, in the case of Puerto Rico, through "two private facilities under contract."[4]

For the limitations included in Illinois' program, the Court is directed to the addendum to Brief of Appellant Miller, pp. 7a-67a.

Illinois submits that the Secretary's approval of these various plan restrictions, some of which are specific to a particular diagnosis (mental illness) or a particular condition (those requiring whole body CT scans or more than two therapeutic injections per month), is additional evidence of the Secretary's traditional willingness to permit individual states to shape their programs of medical assistance under Title XIX to meet their individual needs. This approach, entirely proper under, indeed, required by the provisions of Title XIX, is also inconsistent with the legal position which the Secretary urges through the Solicitor General in footnote 23.

A fuller understanding of the significance of footnote 23 can be gleaned by a perusal of briefs and correspondence filed

[4] Counsel obtained the information summarized in the text in the same manner as the plan provisions governing abortions were accumulated. However, the documents currently on file which counsel reviewed in most cases did not predate 1975. Counsel suggest that a review of earlier plan documents might reveal an even greater variety of approved limitations on the scope of individual state plans.

in conjunction with *Rush* v. *Poythress*, No. 77-2743, *appeal pending* (5th Cir., 1977), a case involving the authority of the State of Georgia and the Secretary of Health, Education and Welfare under Title XIX to refuse to fund "medically necessary" transsexual operations. *See, Rush* v. *Parham*, 440 F.Supp. 383 (N.D. Ga. 1977). In its first brief submitted on behalf of then Secretary Califano, the United States argued that the District Court's ruling that Title XIX required Georgia to fund all transsexual operations deemed medically necessary by a physician was erroneous as a matter of law: (1) The language and legislative intent of Title XIX only require States to utilize reasonable standards and does not compel the coverage of every medical procedure within the categories provided in 42 U.S.C. § 1396d(a)(1)-(5) [the mandatory service categories]; (2) the attending physician's judgment of medical necessity is not controlling on the issue of whether the state must pay for a particular inpatient hospital or physicians' services. See, Brief for the Federal Appellants, pp. 1a-16a, *infra*, filed November 30, 1977.

On April 7, 1980, the United States filed a Supplemental Brief in *Rush* explaining the significance of footnote 23 in its brief herein and withdrawing its argument in Part I of its original brief on Title XIX and medical necessity as far as it applied to the five mandatory service categories. See, pp. 23a-33a, *infra*. Ostensibly, this was done in response to the Secretary's "evolving" ideas regarding Title XIX requirements.[5]

---

[5] The Secretary's revisionary, interpretive efforts are exceedingly troublesome not solely because of their impact on state's discretion to limit the amount duration and scope of services in context other than abortions, but because of their potential for altering the breadth and character of the constitutional issues present in this case. Without conceding any of plaintiffs' arguments, it may be easier to sustain an equal protection challenge to a state medicaid limitation where "congressional intent," as gleaned by the Secretary, prohibits the exclusion of particular items of necessary medical care.

However, as the State of Georgia points out in its letter to the Fifth Circuit objecting to the filing of the Supplemental Brief, p. 19a *infra*, "we find footnote 26 [*sic*, 23] a blatant misstatement of fact." As noted above, the Secretary has not only "authorized participating states to eliminate coverage of . . . particular kind[s] of medically necessary care," n. 23, she has authorized state plan amendments placing limits on abortion funding similar to those at issue here, and narrower than then existing Hyde Amendment criteria. The Secretary's interpretation of the reach of § 1396a(a)(17) in footnote 23 ("[§ 1396 a(a)(17)] was designed to afford each participating state a degree of flexibility in determining the coverage of its plan with respect to persons for whom Medicaid assistance is optional") fails to answer Secretary Califano's counter-argument in the original brief in *Rush:*

> [A]ny interpretation of § 1396a(a)(17) to mean that the "reasonable standards" language was intended to guide the state's decision as to whether the optional services should also be covered becomes superfluous. Such an interpretation would strain all principles of statutory construction since the states are allowed to exclude these services without justification and even in the face of reason.

Brief of the Federal Appellants, pp. 9a-10a, *infra*.

Similarly, the Secretary's assertions that her novel interpretation is a true reading of the original intent of Congress in 1965 is undermined by HEW official releases shortly following the passage of Title XIX. *See,* HEW informational release, October 1966, pp. 34a-39a *infra:* "There will be State-to-State differences in the amount, duration and scope of medical care and services," p. 38a; "Differences among States in adequacy of financial assistance, medical assistance, and social services have characterized the grant-in-aid programs from the beginning." *Id.* In 1966 the Secretary published the "Handbook of Public Assistance Administration, Supplement D, Medical Assistance Program" reproduced in part, pp. 40a-50a, *infra*. Nowhere in Supplement D provisions discussing "amount, duration and

scope" of services can any indication be found that HEW believed that Congress intended participating states to fund each and every conceivable "medically necessary" procedure falling within the five mandatory service categories, or, intended to limit the reach of the "reasonable standards" principle set forth in § 1396a(a)(17) to the optional categories of care.

Congressional amendments to Title XIX since its passage also undermine the inferences of intendment recently gleaned by the Secretary to the effect that states must fund all "medically necessary services" falling within the five mandate service categories. Thus, in 1968 Congress expanded § 1396d(a)(4) by adding clause B to provide for "early and periodic screening and diagnostic" services for minors. Act of Jan. 2, 1968, Pub. L. 90-248, § 302(a), 81 Stat. 905. Again in 1972, § 1396d(a)(4) was expanded by Congress to require the provision of "family planning services." Act of Oct. 30, 1972, Pub. L. 92-603, § 299E(b), 86 Stat. 1384. Neither of the services added by Congress to 1396d(a)(4) can fairly be characterized as "medically necessary." These congressional actions do not permit any inference, as suggested by the Secretary, that the five mandated service categories are the repository of all "medically necessary" care, while the optional service categories encompass "medically unnecessary" or elective care.

Moreover, Director Miller submits that the fatal flaw in the Secretary's interpretation is her failure to give *any* significance to congressional repeal in 1972 of the comprehensive program requirement, Section 1903(e) of the Act [42 U.S.C. § 1396b(e)]. Pub. L. 92-603, § 203. As interpreted by her predecessors, § 1396b(e) was intended by Congress to effect a "broadening of scope of services made available," p. 41a, *infra,* and "progressive improvement in breadth and depth of the medical assistance program, quality of care, and adequacy of administration." *Id.*

The repeal of § 1396b(e) by Congress removed any notion that states were to achieve comprehensive care. There is no evidence that Congress intended to retain a residual "comprehensiveness" requirement limited in scope to the five mandatory categories of services. Therefore, the appropriate inference to be drawn from the available legislative history is that Congress was content with the original limitation it imposed upon states participating in Title XIX, *i.e.,* to employ "reasonable standards . . . for determining eligibility for and the extent of medical assistance . . . consistent with the objectives of" the Act. 42 U.S.C. § 1396a(a)(17).

Illinois urges the Court to reject the Secretary's statements concerning Title XIX's requirements as contained in footnote 23 of the Brief for the United States and as explicated in the Supplemental Brief filed in *Rush* v. *Poythress.* These statements, erroneous as a matter of law, are at odds with Congressional amendments to Title XIX, HEW's original understanding of and established practice under the Act, and therefore deserve none of the respect or deference this Court is inclined to extend the longstanding, consistent views of administrative agencies charged with the enforcement of complicated statutory schemes.[6]

Rather, the Court should conclude that Congress, without regard to the Hyde Amendment, did not intend to compel the states to fund all medically necessary procedures or all medically necessary abortions as a condition of participation and receipt of federal funds under Title XIX. The standard for

[6] If, however, the Court were to defer to the Secretary on the representations in footnote 23, insofar as these statements accurately represent the policy and practice of the agency, then the Court is urged to find this policy and practice to be *ultre vires* as measured by § 1396a(a)(17), or alternatively, to be without any legal force and effect for failure of the Secretary to comply with the rulemaking provisions of 5 U.S.C. § 553.

measuring a state plan limitation on medical care and services was and remains the "reasonable standards" concept in § 1396a(a)(17). That standard is satisfied here where Illinois with due regard for its interest in fetal life funds "life-preserving" abortions and alternative modes of treatment for the complications of pregnancy in the absence of any "reasonable probability that the co-existence of pregnancy [and some other health problem] will materially and significantly shorten the mother's life-span." B. NATHANSON, ABORTING AMERICA 244 (1979), addendum, p. 81a, Brief of Appellant Miller.

III.

CONGRESSIONAL ENACTMENT OF PROFESSIONAL STANDARDS REVIEW LAWS DOES NOT SUPPLANT STATE DISCRETION TO MAKE THRESHOLD DETERMINATIONS OF COVERAGE UNDER TITLE XIX.

The position of the Plaintiffs is that even if the provisions of 42 U.S.C. § 1396 *et seq.* do not mandate compulsory state funding of all "medically necessary" procedures,[7] such a requirement may be found in Congress' establishment of Professional Standards Review Organizations (PSROs). Brief for Appellees, pp. 80-85. Plaintiffs submit that the sole intent of

[7] Although the United States, in its brief, has interpreted the Social Security Act to require states to fund all "medically necessary" procedures, HEW has placed no reliance on the PSRO legislation. *See* Brief for the United States, pp. 45-49. The expertise of the federal agency charged with the administration of the welfare program that the PSRO provisions do not require the funding of all medically necessary procedures is entitled, at least in this context, to some weight. *Cf. Quern* v. *Mandley,* 436 U.S. 725, 743-44 n. 19 (1977); *New York Dept. of Social Services* v. *Dublino,* 413 U.S. 405, 421 (1973); *Udall* v. *Tallman,* 380, U.S. 1, 16 (1965).

Congress in providing for the establishment of PSROs was to ensure that "provision of health care and . . . payment for such services will be made—(1) only when, and to the extent, *medically necessary,* . . ." 42 U.S.C. § 1320c (emphasis added). Defendant Miller contends, however, that Plaintiffs, by narrowly focusing on such language have totally misconstrued Congress' intent in enacting this legislation and the role that PSROs were to play in effectuating this intent. Statutory interpretation requires not merely looking to the language of a particular clause; rather, this Court should view this section in light of the whole statute, *Kokoszka* v. *Belford,* 417 U.S. 642, 650 (1974). All parts of a law should be considered and construed together. *Boys Markets, Inc.* v. *Retail Clerks' Union, Local 770,* 398 U.S. 235, 250(1970). The express language of 42 U.S.C. § 1320c *et seq.* (1976), *as amended by* Act of Oct. 25, 1977, Pub.L.No. 95-142, 91 Stat. 1176 and the relevant legislative history establish that Congress intended to curb the untoward effect that overutilization of medical services was having on health care and its concomitant economic impact on state and federal welfare budgets. Moreover, the proper function of PSROs, within this statutory framework, is to *review* the appropriateness and quality of hospital services provided under the state Medicaid programs; the PSRO legislation in no way purports to modify a State's discretion to *initially* determine those medical services that are covered by a state's Medicaid program.

In examining the tremendous rising costs in implementing the Medicare and Medicaid programs, the Senate Committee on Finance noted:

> The Committee on Finance has, for several years, focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on Medicare and Medicaid. Witnesses testified that a significant proportion of the health services provided under Medicare and Medicaid are prob-

> ably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant. Aside from the economic impact the committee is most concerned about the effect of overutilization on the health of the aged and poor. Unnecessary hospitalization and unnecessary surgery are not consistent. S.REP.NO. 92-1230, 92nd Cong., 2d Sess. 254(1972).

This problem of overutilization led Congress to enact Section 249F of Title II of the 1972 Amendments to the Social Security Act, 42 U.S.C. §§ 1320c-1320c-19, entitled "Professional Standards Review." The Congressional intent behind enactment of this legislation is set forth in Section 1320, which provides that in "order to promote the effective, efficient, and economical delivery of health care services of proper quality" and in light of "the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable *procedures of professional standards review,"* that payment for services performed under Medicare and Medicaid will be made:

> (1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and
>
> (2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion. 42 U.S.C. § 1320c (emphasis added).

The actual responsibilities of the PSRO are set forth in 42 U.S.C. § 1320c-4 and its implementing regulations, 42 C.F.R. § 460 *et seq.*

The statutory responsibility and function of each PSRO is "to assume responsibility for the *review* of the professional activities" of providers "in the provision of health care services and items *for which payment may be made."* 42 U.S.C. § 1320c-4(a)(1)(1977) (emphasis added).

The clear import of this provision is that PSROs are "to assume responsibility for comprehensive and ongoing *review of services covered* under the Medicare and Medicaid programs." H.R. REP.NO. 231, 92nd Cong., 2d Sess. 1 (1971), *reprinted in* [1972] U.S. CODE CONG. & AD. NEWS, 4989, 5391-92 (emphasis added). The 1977 amendments to the PSRO provisions, Act of Oct. 25, 1977, Pub.L.95-142, 91 Stat. 1183, establish Congress' intent that PSRO legislation "would not effect other provisions of existing law relating to determinations with respect to conditions for eligibility to or payments of benefits." H.R.REP. NO. 393, 95th Cong. 1st Sess. 1, 55, *reprinted in* [1977] U.S. CODE CONG. & AD. NEWS, 3039, 3058. PSROs have absolutely no jurisdiction over issues of coverage or scope of benefits. *See* 42 C.F.R. § 463.18 (1979).

42 C.F.R. § 463.27(c)(3) provides that "PSRO determinations shall not preclude appropriate coverage determinations under the provisions of Title XIX of the Act with regard to issues that are not subject to PSRO determination." The regulations promulgated by HEW go on to explain that:

> [s]ections 463.26(c) and 463.267(c) make clear that the Department under Title XVIII and the States under Title XIX may establish *the services that are covered on a uniform basis (scope of benefits).* However, to the extent *individual* medical judgments are required to *implement these coverage rules,* it is the PSRO's responsibility and authority to make these medical judgments which must be followed by the Medicare fiscal agents and State Medicaid agencies.

43 Fed.Reg. 7406 (Feb. 22, 1978) (emphasis added). Plaintiffs, however, place much reliance on the fact that the 1972 PSRO statute requires that PSROs develop appropriate "norms of care, diagnosis, and treatment based upon typical patterns of practice in its region (including typical lengths-of-stay for institutional care by age and diagnosis) as principal points of evaluation and review." 42 U.S.C. § 1320c-5(a) (1976). Brief for Appellees, pp.83-84. Plaintiffs go on to point out that in 1977 Congress amended the PSRO provisions to avoid "disruptive duplicative reviews." H.R.REP. NO. 393(I), 95th Cong., 1st Sess.54, *reprinted in* [1977] U.S. CODE CONG. & AD NEWS, 3039, 3056. Finally, plaintiffs, relying on language from 42 U.S.C. § 1320c-7(c) (1976), *as amended by* Act of Oct. 25, 1977, Pub.L. 95-142, 91 Stat. 1185 boldly state that "[a] PRSO review is 'the conclusive determination on' issues of medical necessity 'for purposes of payment under this chapter, and no reviews with respect to those determinations shall be conducted . . . [by] state [Medicaid] agencies.'" Brief for Appellees, pp. 84-85. Plaintiffs' reliance on § 1320c-7(c), however, is without basis. As a preliminary matter, PSRO review is conclusive with respect to determinations made pursuant to 42 U.S.C. § 1320c-4(a)(1) 4(a)(1) & (2). Defendant Miller has established, and plaintiffs have refused to recognize that § 1320c-4(a)(1) provides for PSROs assuming the responsibility for *reviewing* professional activities within their respective areas; this section in no way affects the State's discretion to initially determine what services are covered by a State's Medicaid plan. Moreover, such PSRO determinations are subject to the provisions of 42 U.S.C. §§ 1320c-8 & 1320c-20(a)(1), (d)(3). Section 1320c-8 provides for administrative review whenever a beneficiary, recipient of benefits, provider or practitioner is "dissatisfied with a determination with respect to a claim made by a [PSRO] in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of § 1320c-4(a) . . . ." Far from substantiating the wide

physician discretion, urged upon this Court by plaintiffs, to initially determine which services are covered, this section makes clear the fact that the PSRO's function is to undertake the case by case review of individual requests for reimbursements, subject to administrative review, and to ensure that no treatment which is not medically necessary is reimbursed.

The restriction of Section 1320c-20(a)(1) provides that a PSRO determination is not conclusive "unless such organization has entered into a memorandum of understanding, . . . , with the single State agency responsible for administering [the State Medicaid plan]". The objective of such a memorandum is to facilitate efficient utilization review and remove any overlap between the PSRO and the State agency; the memorandum "delineat[es] the relationship between the [PSRO] and the State agency' as well as providing for the exchange of data or information, administrative procedures, and coordination mechanisms. Section 1320c-20(d)(3) provides for State agency challenge to PSRO review determinations when the agency presents reasonable documentation; if HEW determines that the PSRO's review determinations have "caused an unreasonable and detrimental impact on total State [Medicaid] expenditures . . . and the appropriateness of care received by [Medicaid recipients]," then, unless HEW finds that the PSRO has taken appropriate corrective action, it *must* suspend the PSRO's authority to make conclusive review determinations. The clear import of these limitations is that Congress did not intend to vest physicians in PSROs with the wide discretion to initially determine what services are "medically necessary." Rather, Congress' objective was to curtail the unchecked exercise of physician discretion in order to promote the underlying policies of efficient utilization review and proper health care services for Medicaid recipients. As HEW has stated, "[i]t was because the Medicare fiscal agents and State Medicaid agencies were determined not to be performing effective utilization review by Congress that the Congress instituted the PSRO concept . . ." 43 Fed.Reg. 7406 (Feb. 22, 1978).

IV.

THE "MEDICALLY NECESSARY" ABORTION SERVICES WHICH PLAINTIFFS SEEK ARE ESSENTIALLY "PREVENTIVE" SERVICES WHICH ILLINOIS MAY FREELY EXCLUDE UNDER TITLE XIX.

Oren Richard Depp, III, M.D. has stated that in his opinion the medical treatment which indigent women "need" short of circumstances covered by the Illinois statute is treatment that "seeks to avoid risks to 'health,' " Depp. affidavit, Joint Appendix, p.104. Dr. Depp explains the basis for this perceived "need" as follows: "[T]he vast majority of medical problems associated with pregnancy appear during the early stages of pregnancy as uncertain health risks and do not reach the level of life-threatening or severe and long lasting health problems until later." Depp. affidavit, Joint Appendix, p. 105. Thus abortions are "necessary" to prevent future health problems and to avoid risks to health and not to *treat* the "vast majority of medical problems" which may co-exist with pregnancy during the first trimester. Defendant submits that this characterization of the types of abortions for which plaintiffs seek funding defines those services as "preventive" treatment.

"Preventive" care under Title XIX is not the same as medically unnecessary care or elective treatment. The Secretary of Health, Education and Welfare in a rule promulgated in the Code of Federal Regulations has defined "Preventive services" as follows:

> [S]ervices provided by a physician .... to—
>
> (1) Prevent disease, disability, and other health conditions or their progression;
>
> (2) Prolong life; and
>
> (3) Promote physical and mental health and efficiency.

42 C.F.R. § 440.130(c).

It follows therefore that the "vast majority" of the abortions which plaintiffs characterize as "medically necessary" are in fact properly characterized as a "preventive service" designed to "prevent disease, disability .... or their progression." This is especially true of those abortions claimed to be necessary for "mental health" reasons.

There is no statutory mandate under Title XIX by which Illinois is compelled to fund "preventive services," conceded by all parties to this appeal to fall within the optional categories of service. 42 U.S.C. § 1396d(a)(6)-(17). Accordingly, Illinois is free to exclude so-called "medically necessary" abortions which are essentially preventive in nature, and may validly elect to limit abortion funding to circumstances necessary for the preservation of life as that standard has been interpreted in Appellant Miller's Brief, p. 43-44: "There must ... be a reasonable probability that the coexistence of pregnancy [and diseases complicating pregnancy] will materially and significantly shorten the mother's life" or that "pregnancy raises the risk of imminent death," quoting from B. NATHANSON, ABORTING AMERICA 244 (1979).

V.

P.A. 80-1091 IS A RATIONAL MEANS TO PURSUE THE STATE'S LEGITIMATE INTEREST IN FETAL LIFE.

Plaintiffs argue that Illinois' adoption of a "life preservation" standard for the funding of public assistance abortions demonstrates "Illinois' reckless unconcern with actual maternal life and health and is an irrational way to serve any legitimate interest" in fetal life. Brief of Appellees, p. 40. Disclaiming any "fundamental right to a publicly funded abortion", Brief of Appellees, p. 42, plaintiffs urge affirmance of the District Court's decision based upon Illinois' alleged discrimination against the "fundamental right ... in making the abortion decision" by denying funds for a particular medical procedure

within an otherwise comprehensive medical assistance program covering "all medically necessary care". Brief of Appellees, pp. 42-43.

However, as Illinois does not have a comprehensive Title XIX program and does not purport to cover "all medically necessary care", plaintiffs argument is inapposite and the scope of Illinois' program does not define the discrimination, if any, here.

Due to Illinois' willingness to fund alternative modes of care and treatment for the complications of pregnancy, the Court should be hesitant to accept plaintiffs' contention that Illinois has erected a "direct purposeful barrier" to medical care *per se* and thereby has "penalized" the decision to abort. See, Brief of Appellees, pp. 46-47, relying on the decision in *Memorial Hospital* v. *Maricopa County,* 415 U.S. 250 (1974).

Plaintiffs purport to find support for application of the "penalty" analysis by reference to the "Illinois legislature's *precise* purpose . . . to prevent as many women as possible from exercising" their right to decide to abort. Brief of Appellees, p. 48. Defendant concedes that any regulatory or appropriation measure, be it federal or state in origin, may affect the behavior of those regulated and who receive public funds. This concession, however, does not establish that plaintiffs or the Court may divine in P.A. 80-1091 a "precise purpose" to penalize the exercise of a right unless such purpose be found either expressly in, or by necessary implication from the words of the statute itself. To the extent that plaintiffs' argument here may concern legislative *motivation,* this Court has often stated that the legislators' state of mind is irrelevant and that constitutionality of legislation should be determined solely by a law's effects. *United States* v. *O'Brien,* 391 U.S. 367 (1968); *Palmer* v. *Thompson,* 403 U.S. 217 (1971); *cf., Washington* v. *Davis,* 426 U.S. 229 (1976); *Village of Arlington Heights* v. *Metropolitan Housing Development Corp.,* 429 U.S. 252 (1976).

The debates surrounding P.A. 80-1091, Joint Appendix, pp. 42-88, do not show that the legislators who voted for the bill were single-mindedly motivated by a desire to "penalize" welfare mothers or to work a discriminatory denial of medical care. The debates addressed a wide variety of factors and considerations, foremost of which were the desire to promote fetal life and to respect the moral beliefs of the legislators' constituents that public funds should not be used to finance any abortion unless necessary to preserve the woman's life. Supporters of P.A. 80-1091 countered suggestions of discrimination by noting that "the state currently makes no pretense of paying for any and all medical procedures." Representative Leinenweber, Joint Appendix, p. 43.

There is not a single documentation of fact in the record below as to the discriminatory *impact* of P.A. 80-1091 since its enactment on indigent pregnant women in Illinois apart from the speculations and fears to be found in the affidavits of plaintiffs-affiants. If actual incidents of maternal health impairment are documented in the future, it would remain to be demonstrated that *but for* P.A. 80-1091 no such health impairment would have occurred. And even were some causal connection established between the enforcement of the law and an actual increase in "maternal morbidity and mortality", *Zbaraz* v. *Quern,* 469 F.Supp. 1212, 1220 (N.D. Ill. 1979), the determination of the rationality of P.A. 80-1091 as a means of promoting the state's interest in fetal life would turn, in part, upon the empirical measurement of any such impact, and especially upon whether health impairment was short or long term. As this Court recently observed in a different context:

> The process of making the determination of rationality is, by its nature, highly empirical, and in matters not within specialized judicial competence or completely commonplace, significant weight should be accorded the capacity of Congress to amass the stuff of actual experience and cull conclusions from it. *United States* v. *Gainey,* 380 U.S. 63, 67, 85 S.Ct. 754, 757, 13 L.Ed.2d 658 (1965).

Usery v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 28 (1977) (Judicial deferral to legislative presumptions regarding disability and entitlement to benefits under the Coal Mine Health and Safety Act of 1969).

Charges by plaintiffs that the legislative action on review is irrational or that the state has abandoned any "neutral stance" by refusing to fund all "medically necessary" abortions are wide of the mark. Given the wide spectrum of informed opinion which reasonable men and women hold on the controversial and unsettled questions of abortion morality, limited state financing of abortions may well be the most "neutral stance" a state can take while dispassionate scientists, shunning simplistic slogans and ideological manipulations of fact, seek further answers to the questions posed:

> The key practical question [in the abortion debates] is to determine when a fetus becomes human. . . . This essential human quality, I believe, can only be our intelligence. . . . The particular sanctity of human life can only be identified with the development and functioning of the neocortex. We cannot require its full development because that does not occur until many years after birth. But perhaps we might set the transition to humanity at the time when neocortical activity begins, as determined by electroencephalography of the fetus.

C. SAGAN, DRAGONS OF EDEN—SPECULATIONS ON THE EVOLUTION OF HUMAN INTELLIGENCE, 208 (1977)

It is the *raison d'etre* of the state to preserve and promote the sanctity of human life. While our scientists are searching for and finding new answers to fetal development and our perinatal physicians are relentlessly pressing back to an earlier point in time of fetal development the point at which a fetus can, with technological life support systems, sustain life outside of the womb, the rationality of state action in this area might well be judged by how efficacious are the efforts of the state to preserve and promote the health, life and well-being of *both* the

mother and the fetus in a *mutually interdependent fashion.* State retention of fiscal autonomy to limit abortion funding by a medically sophisticated "life preservation" standard while simultaneously providing funds for childbirth and alternative modes of treatment for the health problems of the pregnant mother fosters this approach.

By adopting such an approach the legislature does not, "by adopting one theory of life, . . . overide the rights of the pregnant woman that are at stake." *Roe* v. *Wade,* 410 U.S. 113, 162 (1973). The right to decide to abort under P.A. 80-1091 is preserved here and is as free from active state interference as it was in *Maher* v. *Roe,* 432 U.S. 464 (1977). Thus, despite plaintiffs' insinuations of base legislative motive and invidious discrimination, the Court should not be quick to distrust on equal protection grounds a state's fiscal policy encouraging childbirth formulated by elected representatives of the people which "places no obstacles-absolute or otherwise—in the pregnant woman's path to a [medically necessary] abortion." 432 U.S., at 474.

CONCLUSION

Defendant-Appellant Miller prays this Court to reverse the decision of the District Court holding the Hyde Amendment and Illinois P.A. 80-1091 unconstitutional, and to reverse, in part, the decision of the Circuit Court of Appeals holding that, without regard to the Hyde Amendment, Title XIX forbids Illinois to limit its funding of abortions to those necessary for the preservation of the life of the pregnant woman.

Respectfully submitted,

WILLIAM J. SCOTT,
Attorney General of Illinois

Attorney for Appellant.

WILLIAM A. WENZEL, III,
JAMES C. O'CONNELL,
ELLEN P. BREWIN,
Special Assistant Attorneys General
130 North Franklin Street, Suite 300
Chicago, Illinois 60606
(312) 793-2380
Of Counsel

APPENDIX

No. 77-2743

IN THE

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

CAROLYN RUSH (Pseudonym)

Plaintiff-Appellee,

vs.

DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and JOSEPH A. CALIFANO, Jr., Secretary, Department of Health, Education, and Welfare,

Defendants-Appellants.

On Appeal From
The United States District
Court for the
Northern District
of Georgia

BRIEF FOR THE FEDERAL APPELLANTS

BARBARA A. BABCOCK
Assistant Attorney General
WILLIAM L. HARPER
United States Attorney
ROBERT J. CASTELLANI
Assistant United States Attorney
WILLIAM KANTER
Attorney
Civil Division Appellate Section
Department of Justice
CARL H. HARPER
Regional Attorney
EVE H. GOLDSTEIN
Assistant Regional Attorney
STEPHEN P. GEORGESON
Assistant Regional Attorney
Department of Health, Education,
and Welfare

Address:
428 U.S. Courthouse
56 Forsyth Street, N.W.
Atlanta, Georgia
Phone: 404/221-6551

No. 77-2743

IN THE

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

CAROLYN RUSH (Pseudonym)

Plaintiff-Appellee,

vs.

DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and JOSEPH A. CALIFANO, Jr., Secretary, Department of Health, Education, and Welfare,

Defendants-Appellants.

On Appeal From The United States District Court for the Northern District of Georgia

BRIEF FOR THE FEDERAL APPELLANTS

STATEMENT OF THE CASE

Course of Proceedings and Disposition in Court Below

The Secretary adopts by reference the State appellant's statement of the course of proceedings and disposition in the Court below at pages 2-7 of the State's previously filed brief.

Statement of Facts

This was an action for declaratory, injunctive and mandamus relief against state and federal officials seeking financial reimbursement under Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.* (1970) (hereinafter "Medicaid") for a particular type of surgery generally referred to as sex reassignment or transsexual surgery. Payment for this medical service has been denied by the state defendants pursuant to a State Medicaid Plan, approved by the Department of Health, Education, and Welfare (hereinafter "the Secretary"), which prohibited reimbursement for "transsexual operations." Plaintiff alleged that the denial of payment for this service violated her rights[1] under the Equal Protection Clause of the Fourteenth Amendment and 42 U.S.C. §§ 1396d(a)(1) and (5) which require that state plans provide inpatient hospital services and physicians' services to the categorically needy.[2] Based on these allegations, plaintiff petitioned the District Court to enjoin application of the challenged state plan provisions and order reimbursement for her transsexual surgery. With respect to the Secretary, plaintiff sought a mandamus requiring him to disapprove Georgia's existing state plan for Medicaid.

Upon cross motions for summary judgment, the District Court granted judgment in favor of plaintiff. Specifically, the District Court held that:

> "[T]he Georgia State Medicaid Plan and its attendant regulations insofar as they irrebuttably deny Medicaid benefits for transsexual surgery, which involves procedures within the five required categories of 42 U.S.C. §§ 1396(a)(13)(B), 1396d(a)(1)-(5) are DECLARED

[1] Plaintiff, although anatomically male, has stated in briefs that she prefers use of the feminine pronoun.

[2] The categorically needy include needy families with dependent children, the aged, the blind, and disabled. 42 U.S.C. § 1396a(a)(1)(A).

> invalid as a violation of plaintiff's federally afforded rights. The State Defendant: (1) is ENJOINED from application of the State Medicaid Plan and regulations insofar as they irrebuttably deny Medicaid benefits for transsexual surgery and (2) is ORDERED to approve plaintiff's petition for Medicaid reimbursement of the inpatient hospital and physicians' services related to the proposed surgery. The Federal defendant is ORDERED to disapprove the Georgia State Plan and its attendant regulations insofar as they irrebuttably deny Medicaid coverage for transsexual surgery involving services or procedures within the five required categories of 42 U.S.C. §§ 1396(a)(13)(B) and 1396d(a)(1)-(5)."

The Court based its holding on two major findings: (1) that "Medicaid coverage [for services set forth in 42 U.S.C. § 1396d(a)(1)-(5)] is not optional or discretionary for necessary medical treatment of eligible recipients" (Record, p. 463) and (2) that "the attending physician's judgment concerning appropriate treatment where medically necessary must suffer no interference." (Record, p. 464). Taken together these findings mean that no physicians' or inpatient hospital services can be excluded from a state plan, or, conversely, that the state must provide payment for any and all such services when they are deemed necessary by the attending physician. It is this order, and more particularly the premises on which it is based, which the Secretary submits are in error. A stay of the order pending appeal was granted by this Court on September 28, 1977.

Nature of The Medicaid Program

The operation of Medicaid is governed by Title XIX of the Social Security Act and by regulations promulgated thereunder. Title XIX established a cooperative federal-state program "[f]or the purpose of enabling each state, as far as practicable under the conditions in each state, to furnish medical assistance" to certain needy individuals "whose income and re-

sources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396; *Opelika Nursing Home, Inc.* v. *Richardson,* 448 F.2d 658 (5th Cir. 1971). States are not required to institute a Medicaid program, but if they choose to do so, they must submit to the Secretary of Health, Education, and Welfare a satisfactory "state plan" which fulfills all requirements of the Act. *See* 42 U.S.C. § 1396a. Included among those requirements which a state must meet in order to obtain plan approval and continued federal funding is the condition set forth in 42 U.S.C. § 1396a(a)(13)(B) that states must provide to the categorically needy, those services set forth in 42 U.S.C. § 1396d(a)(1)-(5). The five general categories of medical services which must be included in the state plan are: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing facility, periodic screening and diagnosis of children, and family planning services; and (5) physicians' services. 42 U.S.C. §§ 1396a(a)(13)(B) and 1396d(a)(1)-(5).[3]

The state plan describes the nature and scope of the state's Medicaid program and provides assurances that the state will administer its program in conformity with the requirements of the federal statute, regulations and other applicable official issuances of the Department. 45 C.F.R. § 201.2. If the state submits a plan which fulfills all the requirements of the Act, the Secretary must approve it. 42 U.S.C. § 1396a(b); *Johnson's Professional Nursing Home* v. *Weinberger,* 490 F.2d 841 (5th Cir. 1974). The state thereupon becomes entitled to grants of federal funds in reimbursement of a portion of the expenditures which it makes in providing specific types of medical assistance to eligible individuals under the plan in accordance with federal conditions. 42 U.S.C. § 1396b; 45 C.F.R. § 201.5. Georgia

[3] Although the states need not extend Medicaid coverage beyond the five basic classes of services, Georgia has chosen to provide coverage for additional medical services for the categorically needy.

participates in the Medicaid program under an approved state plan.

The Medicaid programs are administered by the states and not the federal government. *See Johnson's Professional Nursing Home* v. *Weinberger, supra.* While a number of federal legal and policy provisions affect state action under the program, it is the states which have responsibility, *inter alia,* for establishing the level of reimbursement for providers of services under Medicaid, determining the conditions of provider participation in the program, entering into provider agreements establishing the scope of services to be offered under the particular state's program, determining the level of state appropriations for the program and affording fair hearings. *See generally* 42 U.S.C. § 1396a. The Secretary may perform none of these functions.

Once the state plan is approved, the Secretary's function is largely limited to making payments to the state for appropriate expenditures under the plan. The Secretary also maintains general oversight of the state's program to ascertain whether the state is fulfilling its plan commitments. Should the state's compliance with federal requirements come into question, the Secretary attempts to resolve such problems by consultation and negotiation with the state. *See generally* 45 C.F.R. § 201. If the state fails to correct the deficiency and the Secretary determines that the deficiency constitutes a failure "to comply substantially" with federal requirements, the statute requires the Secretary to terminate all or part of the state's title XIX funds, but only after notice to the state and opportunity for hearing. 42 U.S.C. § 1396c; 45 C.F.R. §§ 201, 213.

SUMMARY OF THE ARGUMENT

A state is not required to provide payment under its Medicaid program for every medical service which the treating physician determines to be medically necessary. Instead, a state may use reasonable standards in determining the extent of medical assistance to be covered. A fair reading of Title XIX demonstrates that the application of this reasonable standards test is not limited to the decision by a state whether to reimburse the "optional" services. 42 U.S.C. §§ 1396d(a)(6)-(17). Instead, this test also guides a state in its determination of whether to exclude certain inpatient hospital or physicians' services. 42 U.S.C. § 1396d(a)(1) and (5).

Furthermore, the District Court erred in holding that the attending physician's professional judgment concerning medical necessity must suffer no interference. The Medicaid statute in fact mandates review of the attending physician's judgment in a number of areas.

ARGUMENT

I.

THE LANGUAGE AND LEGISLATIVE INTENT OF TITLE XIX SUPPORT THE POSITION THAT THE STATES ARE REQUIRED ONLY TO UTILIZE REASONABLE STANDARDS AND ARE NOT COMPELLED TO PAY FOR ALL INPATIENT HOSPITAL AND PHYSICIANS' SERVICES.

It is the Secretary's position on appeal that a state may employ reasonable standards in determining the extent of medical assistance to be covered under Medicaid and that the lower court erred in holding that a state is compelled to include in its coverage every medical procedure, within the categories provided in 42 U.S.C. § 1396d(a)(1)-(5), which a physician determines to be medically necessary. *See Virginia Hospital Association* v. *Kenley,* 427 F.Supp. 781 (E.D. Va. 1977).

Indeed, it is important to note that the sole Congressionally imposed requirement which deals directly with the extent of medical assistance to be provided under Medicaid is that a state include reasonable standards which are consistent with the objectives of the Act. 42 U.S.C. § 1396a(a)(17). That section of the statute provides that:

> "A State plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of this [Title]."

The Supreme Court, in *Beal* v. *Doe,* ____ U.S. ____, 97 S.Ct 2366 (1977) affirmed that the states, in fashioning the coverage of their Medicaid programs, are required only to employ reasonable standards. Citing § 1396a(a)(17), the Court noted:

> . . . the statute is cast in terms that require participating States to provide financial assistance with respect to five

> broad categories of medical treatments. *But nothing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care.* Indeed, the statute expressly provides that:
>
> > "A State plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . are consistent with the objectives of this [Title] . . ." 42 U.S.C. § 1396(a)(17).
>
> This language confers broad discretion on the States to adopt standards for determining the extent of medical assistance, *requiring only that such standards be "reasonable"* and "consistent with the objectives" of the Act. *Doe* v. *Beal,* ____ U.S. ____ 97 S.Ct. at 2370-71. (emphasis added)

It is by this reasonable standards test that the District Court should have judged the Georgia State Medicaid Plan.

There is no legislative history to indicate precisely what Congress meant when it said that the state plan must include "reasonable standards . . . for determining the extent of medical assistance." However, reasonable interpretation of that phrase and an analysis of Title XIX indicate that Congress intended that the states would have the power to exclude from coverage some services and forms of treatment which might be determined by some physicians to be medically necessary and that the District Court erred in limiting the application of that test to optional services § 1396d(a)(6)-(17), and medically unnecessary services.

The District Court's interpretation of 42 U.S.C. § 1396a(a)(17) is inconsistent with the import of Title XIX. Congress specifically enabled states to categorically exclude from Medicaid coverage those types of medical services listed in 42 U.S.C. § 1396d(a)(6)-(17), the so-called optional services. 42 U.S.C. § 1396a(a)(13)(B) and (C)(i). Thus, any inter-

pretation of § 1396a(a)(17) to mean that the "reasonable standards" language was intended to guide the state's decision as to whether the optional services should also be covered becomes superfluous. Such an interpretation would strain all principles of statutory construction since the states are allowed to exclude these services without justification and even in the face of reason. Nor is there any indication that Congress intended the States' discretion to be limited to what would, in most cases, be a relatively small number of not medically necessary services they might choose to provide.

The discretion afforded the states under the reasonable standards test is not unlimited. The Secretary has provided by regulation that the medical services covered "... must be sufficient in amount, duration and scope to reasonably achieve their purpose." 45 C.F.R. § 249.10(a)(5)(i). The states "may not arbitrarily deny or reduce the amount, duration, or scope of, such services ... solely because of the diagnosis, type of illness or condition." *Id.*[4] This regulation is consistent with the statutory intent of allowing states to determine the amount of medical assistance to be provided by a reasonableness stan-

---

[4] In a recent case brought to the attention of the Court *Doe* v. *Minnesota Department of Public Welfare,* 46 U.S.L.W. 2160 (August 19, 1977), the Minnesota Supreme Court held that the state's exclusion of transexual surgery from its state plan violated this regulation. That Court did not find that 42 U.S.C. §§ 1396d(a)(1) and (5) required the state Medicaid plan to include every inpatient hospital or physicians' service which a treating physician deemed medically necessary. Rather the only federal violation found by the Court was denial of services on the basis of type of illness or condition. The Court noted that evidence presented by plaintiff that surgery was the only effective therapy for transsexualism had been uncontested. In the instant case, however, the Secretary has submitted evidence to show that psychotherapy is an effective form of treatment, thus placing in issue plaintiff's assertion that Georgia's refusal to reimburse the cost of surgery is tantamount to discrimination on the basis of type of illness.

dard. Great deference should be given to the Secretary's interpretation of the statute. *Beal* v. *Doe, supra,* at p. 2372; *New York Department of Social Services* v. *Dublino,* 413 U.S. 405 (1973). This is particularly true where the Secretary's interpretation is consistent with the statutory objective of enabling "each State, *as far as practicable* under the conditions in the State" to furnish medical assistance to the needy. 42 U.S.C. § 1396. (emphasis added).

As has been previously demonstrated, the United States Supreme Court, in *Beal* v. *Doe,* has unequivocally stated that Title XIX grants the states broad discretion to adopt standards for determining the extent of medical assistance, with the only provision being that such standards be reasonable and consistent with the objective of the Act. It is the position of the Secretary that the Supreme Court's decision allows a state plan to exclude from coverage services which a physician may deem to be medically necessary for his patient, so long as the state's action has a reasonable basis and does not discriminate on the basis of diagnosis. 45 C.F.R. § 249.10(a)(5)(i). The District Court, however, while recognizing that a state has reasonable discretion within the five mandatory categories to formulate a state plan, held that, under *Beal,* such discretion does not extend to those services which are deemed medically necessary by a treating physician. In doing so the District Court relied upon the following language:

> "Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund *unnecessary*—though perhaps desirable—medical services," *Id.* at 2371. (emphasis in original). Record, p. 463.

This passage does not indicate that *all* medically necessary treatment must be covered by Medicaid. What the Court was saying was that, if such treatment were excluded from coverage, serious statutory questions would be raised since the state

would have a heavier burden of demonstrating compliance with the reasonable standards test since a service determined to be medically necessary had been excluded. The Secretary agrees that such questions are arguably raised in the case *sub judice*. It is for this reason that he submitted the affidavits of two psychiatrists experienced in the treatment of transsexuals who expressed the opinion that psychotherapy (available under the Georgia State Plan) was not only an alternative, but a preferable mode of treatment. That evidence was necessarily ignored by the District Court which elevated the opinion of the treating physician above that of the state or experts in the field. This, it is submitted, was not the intention of Congress or the meaning of the Supreme Court in *Beal*.

Rather than categorically prohibiting a state from refusing to reimburse the cost of any medically necessary procedure, the Supreme Court was indicating that it will demand that the state provide greater justification for the exclusion of such services. The State appellant should be given the opportunity on remand to provide such justification, and the Secretary the opportunity to show that, even measured against the heavier burden imposed by *Beal*, he did not abuse his discretion in approving the Georgia Plan.

II.

THE ATTENDING PHYSICIAN'S JUDGMENT OF MEDICAL NECESSITY IS NOT CONTROLLING ON THE ISSUE OF WHETHER THE STATE MUST PROVIDE PAYMENT FOR PARTICULAR INPATIENT HOSPITAL OR PHYSICIANS' SERVICES.

The Supreme Court in *Beal* v. *Doe* remanded for consideration by the District Court the issue whether Pennsylvania's practice of requiring concurrence by two physicians with the judgment of the attending physician that an abortion is medically necessary was in violation of Title XIX. In so doing, the

Court noted that the record was not complete enough to show "the precise role played by these two physicians, and ... whether this requirement interferes with the attending physician's medical judgment *in a manner not contemplated by the Congress.*" 97 S. Ct. at 2373. (emphasis added). While the Court expressed no opinion on the appropriate role of the attending physician under the statutory scheme, it is clear from the underlined language and from the fact that the remand was ordered, that the Court did not view the Medicaid Act as providing *carte blanche* to the physician for any and all services he might deem necessary.

But the District Court in the instant case held that "the attending physician's professional judgment concerning appropriate treatment where medically necessary must suffer no interference." (Record, p. 464). The Court was careful to limit its holding to state plan provisions which "irrebuttably [deny] coverage of any services or procedures within the five required categories" (*Id.*, p. 465), and denied any intention to interfere with the state's responsibility to conduct utilization review or control. (*Id.*, p. 469 at n. 13). Nevertheless, it is difficult to reconcile the District Court's view that the attending physician's opinion cannot be challenged for purposes of Medicaid reimbursement with a statutory scheme that mandates such processes as utilization review (42 U.S.C. § 1396a(a)(30)), review by Professional Standards Review Organizations (42 U.S.C. § 1320c *et seq.*), and "medical reviews" of nursing home patients (42 U.S.C. §§ 1396a(a)(20) and 1396a(a)(31)).[5]

For example, an attending physician might make a diagnosis of gastric ulcers and admit the patient for surgery.

---

[5] It should be noted that neither utilization review nor any other provision of the Medicaid Act precludes the physician from performing any service he deems necessary. These provisions are relevant only to the issue of whether the State and federal government will provide reimbursement for the procedure.

However, if his evaluation of his patient's condition was deemed unwarranted (*i.e.*, was not supported by adequate laboratory or clinical findings) the utilization review team would recommend discharge even though continued hospitalization would be justified were the attending physician's diagnosis correct. The recommendations of the utilization review process are not binding in the sense that discharge can be required; however, the State is not required to pay for treatment in the face of contrary utilization review findings.[6]

The Secretary recognizes that the above example may be distinguishable because no "irrebuttable presumption" is involved. Nevertheless, the opinion of the treating physician is ignored despite the fact that he believes hospitalization is medically necessary and all parties agree that, if his diagnosis is in fact accurate, hospitalization and surgery are necessary and appropriate.

Similar results will occur when professional standards review organizations become fully operational and take over the functions currently performed by utilization review. 42 U.S.C. § 1320c—4. Indeed, the PSRO legislation envisions that each PSRO will adopt certain standards and norms for treatment from which departures by the attending physician will have to be justified. 42 U.S.C. § 1320c—9. Likewise, medical review teams are required to visit nursing homes annually and review the record of each patient to determine whether appropriate treatment is being rendered and to determine whether the patient actually requires the level of care he is receiving. 42 U.S.C. § 1396a(a)(26) and 1396a(a)(31). Surely a statutory scheme which envisions these kinds of reviews of the attending physician's judgment in particular cases cannot be said to have foreclosed a judgment by the state that certain kinds of treatment will not be paid for, when other forms of treatment,

[6] Should the State determine not to make payment, the patient is entitled to a hearing pursuant to 45 C.F.R. § 205.10.

equally acceptable for all or most patients suffering from the condition, are covered under the plan. It is this kind of judgment which the State of Georgia has made and the Secretary approved. If it was wrong, this can be determined on remand when the District Court considers whether exclusion of transsexual surgery was in fact reasonable pursuant to the standards outlined in Section I of this Argument. It is respectfully submitted that neither Congress nor the Supreme Court intended to place the attending physician on the level prescribed by the District Court—subject to "no interference" or limitation.

CONCLUSION

On the basis of the foregoing, the Secretary respectfully urges that this Court reverse this order of the District Court, which granted summary judgment for plaintiff and denied summary judgment for the Secretary.

Respectfully submitted,

WILLIAM L. HARPER
United States Attorney

By: _____

Robert J. Castellani
Assistant United States Attorney

Carl H. Harper
Regional Attorney

Eve H. Goldstein
Assistant Regional Attorney

Stephen P. Georgeson
Assistant Regional Attorney

Department of Health, Education,
and Welfare

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20530

Address Reply to the
Division Indicated
and Refer to Initials and Number

January 24, 1980

TELEPHONE:
(202) 633-3525

WK:LMC:wm
137-79-433

Mr. Gilbert F. Ganucheau
Clerk, United States Court of Appeals
for the Fifth Circuit
Room 102, 600 Camp Street
U.S. Court of Appeals Courthouse
New Orleans, LA 70130

Re: *Carolyn Rush (Pseudonym)* v. *T. M. "Jim" Parham, etc., et al.; David Poythress, etc.; Joseph A. Califano, Jr., Secretary of Health, Education and Welfare* (C. A. 5, No. 77-2743)

Dear Mr. Ganucheau:

The above-captioned case was argued and submitted on September 24, 1979. The panel included Chief Judge Brown and Circuit Judges Tjoflat and Garza.

The Solicitor General has just filed a brief on behalf of the Department of Health, Education and Welfare which may affect the proper disposition of this appeal. *United States of America* v. *David Zbaraz*, No. 79-491 (Supreme Court). We are enclosing copies of that brief and ask that you distribute them to the members of the panel as soon as possible. We further ask that you direct their attention to the footnote which appears at pages 43 and 44 of that brief.

We will formally move for leave to file a supplemental memorandum which will explain the effect of the *Zbaraz* footnote upon the *Rush* appeal within approximately two weeks.

Very truly yours,

WILLIAM KANTER

William Kanter, *Assistant Director*
Appellate Staff

LINDA M. COLE

Linda M. Cole
Attorney, Appellate Staff

cc: See page 2.

The Department of Law
State of Georgia
Atlanta
30334

THUR K. BOLTON
TORNEY GENERAL

132 STATE JUDICIAL BUILDING
TELEPHONE 656-3300

January 29, 1980

Mr. Gilbert F. Ganucheau, Clerk
United States Court of Appeals
Fifth Circuit
Room 102, 600 Camp Street
U.S. Court of Appeals Courthouse
New Orleans, Louisiana 70130

RE: *Carolyn Rush* v. *T. M. "Jim" Parham, etc., et al.*
Civil Action No. 77-2743.

Dear Mr. Ganucheau:

We have received a copy of a letter from Ms. Linda M. Cole of the United States Department of Justice asking that you distribute copies of the federal brief in *United States of America* v. *David Zbaraz,* No. 79-491 (Supreme Court) to members of the panel in the above-captioned case, calling their attention to footnote 23 at pages 43 and 44 of that brief.

The State of Georgia strongly objects to this request. The submission of legal arguments without leave of court, albeit in a separate action, clearly violates the Federal Rules of Appellate Procedure and the local rules of the Fifth Circuit.

While we normally would not comment on substantive matters by letter, we find footnote 26 a blatant misstatement of fact. Federal defendants now seek at this late date to totally change their position as argued in their brief submitted Novem-

ber 30, 1977 and made at their oral argument on September 28, 1979. Federal rules do not permit such abuse of the appellate process.

The federal defendants have, until January 24, 1980, consistently maintained that "A state is *not* required to provide payment under its Medicaid program for every medical service which the treating physician determines to be medically necessary." [Emphasis added.] Federal Appellants' "Summary of Argument," p. 8. The federal appellants now seek to submit a new brief in which a footnote concludes: "[N]either the Medicaid Act nor the Secretary, however, has authorized participating states to eliminate coverage of a particular kind of medically necessary care."

The Justice Department does not argue intervening decisions or new developments. Rather it now seeks to reargue *Rush* from the beginning. The Justice Department has placed the State of Georgia in both an untenable and unfair position to which we strongly object.

We formally move that the brief submitted in *United States of America* v. *Zbaraz,* not be distributed to members of the panel and that the request to file a supplemental memorandum be denied.

Sincerely,

STEPHANIE B. MANIS

Stephanie B. Manis
Staff Assistant Attorney General

SBM/ad

cc: Chief Judge Brown
Judge Tjoflat
Judge Garza
Mr. William Kanter
Ms. Linda M. Cole
Mr. Kenneth Levin

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

CAROLYN RUSH (pseudonym), ***Plaintiff-Appellee,*** **v.** **DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and PATRICIA R. HARRIS, Secretary of Health, Education and Welfare,** ***Defendants-Appellants.***	No. 77-2743

MOTION FOR LEAVE TO DEFER FILING A SUPPLEMENTAL BRIEF FOR THIRTY DAYS

The Department of Justice and the Secretary of Health, Education and Welfare, respectfully request leave to defer filing a supplemental brief until April 7, 1980. The reasons for this motion are as follows:

1. On January 24, 1980, the Department of Justice provided this Court with a brief which the Solicitor General had filed in *United States of America* v. *David Zbaraz,* No. 79-491 (Supreme Court). We called this Court's attention to the footnote which appears at pages 43-44 of that brief and stated that we would seek leave to file a supplemental memorandum explaining how that footnote affected this case within approximately two weeks.

2. In the course of preparing that memorandum, it became clear that any effort to amplify the arguments contained in the footnote or to extend them to areas other than abortion funding could have important ramifications for the Medicaid program as a whole. Accordingly, the Solicitor General has asked both the Civil Division and the

Department of Health, Education and Welfare to provide him with comprehensive memoranda on the subject so that he can define the contours of the government's position. Until this process is complete, the attorneys assigned to this case cannot fully inform this Court of the government's position.

Respectfully submitted,

WILLIAM KANTER

William Kanter (202) 633-5460

LINDA M. COLE

Linda M. Cole (202) 633-3525
Attorneys
Civil Division—Room 3631
Department of Justice
Washington, D.C. 20530

No. 77-2743

IN THE

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

CAROLYN RUSH (pseudonym),

Plaintiff-Appellee,

v.

DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and PATRICIA R. HARRIS, Secretary, Department of Health, Education and Welfare,

Defendants-Appellants.

On Appeal from the United States District Court for the Northern District of Georgia

SUPPLEMENTAL BRIEF FOR THE FEDERAL APPELLANTS

ALICE DANIEL
Assistant Attorney General

WILLIAM L. HARPER
United States Attorney

WILLIAM KANTER
LINDA M. COLE
Attorneys
Civil Division, Room 3631
U.S. Department of Justice
Washington, D.C. 20530
Telephone: (202) 633-3525

CITATIONS

No. 77-2743

IN THE

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

CAROLYN RUSH (pseudonym),

Plaintiff-Appellee,

v.

DAVID POYTHRESS, Commissioner, Georgia Department of Medical Assistance and PATRICIA R. HARRIS, Secretary, Department of Health, Education and Welfare,

Defendants-Appellants.

On Appeal from the United States District Court for the Northern District of Georgia

SUPPLEMENTAL BRIEF FOR THE FEDERAL APPELLANTS

This case was argued and submitted on September 24, 1979. By letter dated January 24, 1980, the federal appellants requested the Clerk of this Court to provide the members of the panel with copies of a brief which the Solicitor General had just filed in *United States of America* v. *David Zbaraz, et al.*, No. 79-491 (Supreme Court). We asked the Clerk to direct the panel's attention to the footnote which appears at pages 43-44 of that brief and stated that we would seek leave to file a supplemental memorandum explaining the effect of that footnote upon this appeal.

The order from which this appeal was taken required the states to fund all medically necessary services falling within five broad categories and held that the treating physician's determination of medical necessity controls the state's obligation to pay. The Secretary raised two issues on appeal: whether the states do in fact have to pay for all medically necessary services within the five categories and whether the treating physician has the sole authority to define medical necessity. The development of policy which is reflected in the *Zbaraz* footnote plainly affects the disposition of the first issue. It has no bearing upon the second.

The first section of this brief will explain how and why the Secretary's interpretation of the Medicaid statute has evolved since the filing of this appeal so that portions of it no longer reflect government policy.[1] The second section will formally withdraw those portions of this appeal. The final section will identify the issues that remain in this case and explain why the withdrawal of one part of the Secretary's appeal does not affect the validity of the other.

A. The development of the Secretary's position focuses upon four statutory provisions: 42 U.S.C. 1396, 42 U.S.C. 1396a (a)(13)(B), 42 U.S.C. 1396a(a)(17) and 42 U.S.C. 1396d(a)(1)-(5). It took place primarily in the context of the three cases below.

1. In March of 1976, the Solicitor General filed a Memorandum for the United States as Amicus Curiae in *Beal* v. *Doe*, No. 75-554 (Supreme Court). That case presented the question of whether the Medicaid statute allowed the states to eliminate coverage of elective abortions. The memorandum cited § 1396 for the proposition that "[t]he principal objective of Title XIX is the furnishing of "medical assistance on behalf of [certain families and individuals] whose income and re-

[1] The attorneys who prosecuted this appeal did not know that the Secretary's views were evolving until her ideas had fully developed and found expression in the *Zbaraz* footnote. They notified this Court immediately.

sources are insufficient to meet the costs of necessary medical services." Memorandum, p. 5. It asserted that § 1396a (a)(13)B) and § 1396d(a)(1)-(5) require the states to provide those families and individuals with five kinds of medical care: (1) inpatient hospital services, (2) out-patient hospital services, (3) laboratory and x-ray services, (4) skilled nursing facility services, periodic screening and diagnosis of children, and family planning services, and (5) physician's services. Memorandum, p. 4. However, the memorandum treated § 1396a(a)(17) as authorizing the states to set some limitations on the types of services which they will cover under their Medicaid plans even when those services fall within the five mandatory categories. Memorandum, p. 5. It asserted that "Congress intended that the participating states would retain substantial flexibility in determining the extent, scope and duration of medicaid coverage, subject only to the requirement of reasonableness and other specific requirements of the Act." Memorandum, p. 6. It concluded that the states could reasonably exclude elective or unnecessary services from coverage. *Id.*

2. In August of 1977, the United States District Court for the Northern District of Georgia decided this case. The Secretary sought and obtained the Solicitor General's authorization to file an appeal which would extend the *Beal* interpretation of § 1396a(a)(17) to a situation in which the treating physician had determined that the excluded service was medically necessary for a particular Medicaid recipient. Since the *Beal* opinion indicated that serious statutory questions would arise if the states invoked § 1396a(a)(17) to eliminate coverage of medically necessary services, the Secretary argued that the states may exclude on an across-the-board basis, services which a treating physician could determine are medically necessary only if they can sustain a heavy burden of proof on the issue of reasonableness. The Secretary also argued that in any event, transsexual surgery was not generally a medically necessary mode of treatment. Opening Brief, pp. 13-14.

3. In April of 1979, the United States District Court for the Northern District of Illinois invalidated the federal statute which restricts the public funding of abortions. The Court held that the equal protection component of the Due Process Clause of the Fifth Amendment requires the government to pay for all abortions deemed medically necessary by the treating physician and performed prior to viability. *Zbaraz* v. *Quern*, 469 F.Supp. 1212 (N.D.Ill. 1979). In preparing the direct appeal to the Supreme Court, the Solicitor General asked the Secretary of Health, Education and Welfare whether the states would have discretion to exclude medically necessary abortions from coverage in the absence of the federal funding restrictions. Abortions may fall within at least three of the five mandatory categories and services—inpatient hospital, outpatient hospital and physicians services. That request prompted the Secretary to re-examine the statute and its legislative history with respect to medical necessity. As a result of an extensive re-examination of the issue, the Secretary concluded that the position advanced in *Beal* and *Rush* was incorrect in so far as it suggested that the Medicaid statute and its implementing regulations permit states to eliminate entirely specific types of services within the five mandatory categories from Medicaid coverage on grounds other than medical necessity. The Secretary concluded that the states could eliminate types of services from coverage only on the basis of medical necessity and not on the basis of some looser standard of reasonableness.[2] In her view, 42 U.S.C. 1396a(a)(17) does not override the provisions of the statute that require the states to provide "at least" the services falling

[2] The Secretary also reviewed extensively HEW's prior administrative practice and concluded that, with a few limited exceptions, the Department had permitted states to exclude from coverage specific types of services falling within the mandatory categories only under a medical necessity standard. Thus, the practical effect of the evolution of the Secretary's interpretation of the Medicaid act should be very small.

within the five mandatory categories.[3] The Solicitor General presented these views to the Supreme Court in *Zbaraz* and we promptly transmitted a copy of that brief to this Court.

B. The Secretary's re-examination of the Medicaid statute requires the withdrawal of two arguments that we presented to this Court. The first concerns the proper interaction between 42 U.S.C. 1396a(a)(13)(B), 42 U.S.C. 1396a(a)(17) and 42 U.S.C. 1396d(a)(1)-(5). The second concerns the proper interpretation of the phrase "necessary medical services" which appears in 42 U.S.C. 1396.

1. In our opening brief to this Court, we argued that Georgia could exclude transsexual surgery from coverage under its state Medicaid plan even though hospital and physician's services fall within the five mandatory categories of treatment. We asserted that 42 U.S.C. 1396a(a)(17) permits each state to define the extent to which it will provide medical assistance under its plan and that the state's authority to limit the scope of its coverage extends to the five mandatory service categories. We further contended that § 1396a(a)(17) establishes the criteria for judging a state's decision to eliminate a particular kind of service from coverage: reasonableness and consistency with the objectives of the Medicaid statute.

[3] The Department's regulations also delineate the scope of discretion States have in excluding services within the mandatory categories from coverage. These regulations prohibit States from "...arbitrarily deny[ing] or reduc[ing] the amount, duration, or scope of a required service [one within the mandatory categories] solely because of the diagnosis, type of illness, or condition." 42 C.F.R. 440.230(c)(1), as corrected, 43 Fed. Reg. 57253 (December 7, 1978). See also 42 C.F.R. 440.230(c)(2). As explained in the preamble when the Department initially issued this regulation, the word "arbitrarily" was added only to specify that the regulation does not prohibit states from setting reasonable limitations "appropriate to medical necessity or utilization review." 39 *Fed. Reg.* 16970 (May 10, 1974). Thus, the regulation prohibits States from excluding from coverage medically necessary services within the mandatory categories based upon the diagnosis or condition of the patient.

After exhaustively re-examining the question, the Secretary concluded that the legislative history of the Medicaid act emphasizes the provision of a minimum program of medical benefits consisting of services within the five mandatory categories listed in 42 U.S.C. 1396d(a)(1)-(5). *See* 42 U.S.C. 1396a(a)(13)(B). The Secretary further concluded that the language and legislative history of 42 U.S.C. 1396a(a)(17) indicates that Congress intended to give the states broad discretion to set eligibility-related requirements—e.g., the level of income and resources that individuals could have and still be eligible, or the comparability of financial eligibility requirements for each categorical group of Medicaid recipients—but that Congress did not intend to authorize the states to exclude types of medically necessary services from coverage. She therefore concluded that states must pay for all medically necessary types of services falling within the mandatory categories unless Congress relieves them of that responsibility by adopting its own funding restrictions. These views are stated in the *Zbaraz* footnote and necessitate the withdrawal of the arguments presented on pages 9-14 of our opening brief.

2. In our letter of August 10, 1979, we called this Court's attention to the decision in *Preterm* v. *Dukakis*, 591 F.2d 121 (1st Cir. 1979). In that case, the court viewed the words "necessary medical services" as forming part of the definition of the beneficiaries of the Act rather than imposing any substantive requirement on the states. *Id.* at 124-125. At oral argument, we asked this Court to follow that strict gramatical reading of 42 U.S.C. 1396.[4]

---

[4] 42 U.S.C. 1396 provides in pertinent part:

> For purpose of enabling each State, as far as practicable under the conditions of such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the cost of necessary medical services * * * there is hereby authorized, to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter * * *.

Upon re-examination, the Secretary has concluded, in agreement with the District Court's decision in this case, that the phrase "necessary medical services" does not have such a limited application. Rather, it constitutes the legislative statement of the purpose of the Act. The Secretary also determined that it constitutes statutory authority for permitting the states to eliminate from coverage unnecessary, although perhaps desirable, medical services falling within the five mandatory categories. Again, these views have been stated in the *Zbaraz* footnote and require the withdrawal of our request on behalf of HEW, that this Court follow *Preterm* in finding that the words "necessary medical services" do not define the scope of the states' obligations under the Act.

C. The Secretary's conclusion that the states must fund all medically necessary type of services falling within the five mandatory categories requires us to withdraw the arguments advanced in support of our first issue on appeal. However, HEW's re-examination of the Medicaid statute and its legislative history have reinforced its belief that the treating physician is not the sole judge of medical necessity. Accordingly, the second issue on appeal remains for decision.

The Supreme Court has held that the Medicaid Act does not require the states to pay for medically unnecessary services. *Beal* v. *Doe*, 432 U.S. 438 (1977). Thus, the critical question is who judges medical necessity. The Secretary has traditionally allowed the states to decide that particular types of services are not medically necessary and to eliminate them from coverage on an across-the-board basis. Indeed, the Department's regulations specifically state that "[a]ppropriate limits may be placed on services based on such criteria as medical necessity***" 42 C.F.R. 440.230(c)(1), as corrected 43 Fed. Reg. 57253 (December 7, 1978). The regulations do prohibit the states from "arbitrarily deny[ing] or reduc[ing] the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition." *Id.* However, as ex-

plained in footnote 3, *supra,* when that regulation was first promulgated, the preamble explained that "arbitrarily" means based on considerations other than medical necessity or utilization review. 39 Fed. Reg. 16970 (May 10, 1979). Thus, the regulation permits States to make reasonable across-the-board determinations about the medical necessity of particular types of services, even within the mandatory categories, and to exclude them from Medicaid coverage on that basis. For example, States have been permitted to exclude cosmetic surgery from coverage.

The Secretary has generally permitted the states to exclude methods of treatment as unnecessary if they are experimental or not generally recognized as effective within the medical community. In the instant case, the Department submitted the affidavits of two psychiatrists both of whom have extensive experience in treating transsexualism and both of whom have serious doubts as to the safety and efficacy of surgery as a form of therapy.[5] Accordingly, the Department adheres to its original position that this case could not properly have been decided on the plaintiff's motion for summary judgment and should be remanded for a determination as to whether Georgia's decision to exclude transsexual surgery and the Secretary's decision to

[5] During her re-examination of the medical necessity question, the Secretary did not decide the extent to which the availability of alternate forms of treatment could form the basis for a permissible exclusion. A decision on this point is not essential to the disposition of this appeal because Georgia has plainly excluded transsexual surgery from coverage on the grounds that it is experimental—*i.e.,* not generally recognized as effective.

approve Georgia's plan constitute valid administrative decisions in accordance with the standards set forth in *Citizens to Preserve Overton Park* v. *Volpe,* 401 U.S. 402 (1971).

Respectfully submitted,

ALICE DANIEL
Assistant Attorney General

WILLIAM L. HARPER
United States Attorney

WILLIAM KANTER

LINDA M. COLE
Attorneys
Civil Division, Room 3631
U.S. Department of Justice
Washington, D.C. 20530
Telephone: (202) 633-3525

JOAN Z. BERNSTEIN
General Counsel

HELEN TRILLING
Special Assistant to
General Counsel
Department of Health,
Education & Welfare
200 Independence Ave., S.W.
Washington, D.C. 20201

Of Counsel.

April, 1980

October 1966 Preliminary

Questions and Answers

on the

MEDICAL ASSISTANCE PROGRAM

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Welfare Administration
Bureau of Family Services

PURPOSE AND GOALS

QUESTION 1

What is the medical assistance program?

Answer: The medical assistance program is title XIX of the Social Security Act. It was authorized by an amendment to the Act and was signed into law by President Johnson on July 30, 1965 (Public Law 89-97).

QUESTION 2

What is the goal of the medical assistance program?

Answer: Medical care of high quality that will be readily available to persons unable to pay for it.

QUESTION 3

How does a State achieve this goal?

Answer: A State achieves this goal by providing the necessary medical care for persons who need it but do not have sufficient income and resources to pay the full cost. The State agency and its local units work with other agencies, organizations, and professional groups in furthering the development and maintenance of adequate resources for the provision of medical care for all persons throughout the State. Specifically, the agency is concerned with eligible persons who need assistance in meeting the costs of their care. The agency sets standards designed to ensure care of high quality, establishes policies and procedures, and makes other arrangements to enable individuals to obtain the care and services they need. It provides social services to assist families in recognizing the need for medical care, in obtaining care promptly, and in making

necessary adjustments in social factors related to medical care. It determines eligibility for assistance, authorizes the expenditures, and makes payments for the care and services received.

QUESTION 4

What are the basic differences between the medical assistance program (title XIX) and the program of health insurance for the aged (title IVIII, or medicare)?

Answer: Title XIX is a Federal-State assistance program, designed to provide medical care for needy persons of all ages under a definition of need defined by each State. Eligibility is determined for the individual or family according to State provisions. This medical assistance program is administered by the States and is financed in part by the State (or State and local) governments and in part (50-83 percent, depending on State average per capita income) by the Federal Government. Since each State determines eligibility and benefits, there will be differences—State by State in who is eligible and for what benefits.

Title XVIII is a federally administered insurance program for the aged, affording two kinds of benefits for persons aged 65 or older: hospital insurance (for hospitalization and related care) and voluntary medical insurance (for physicians' services and some other medical services). Eligibility is a right based on the social insurance principle, and benefits are the same throughout the Nation. The basic program of hospital insurance is financed by deductions from employees' wages and matching taxes paid by employers; for voluntary medical insurance, the individual currently pays $3 a month, and the Federal Government pays the same amount. The Social Security Administration is responsible for formulating policy and administering the program.

QUESTION 5

How does a State's medical assistance program relate to the Federal program of medicare?

Answer: The medical assistance program complements the health insurance provisions by paying the deductible amounts for needy, aged persons who are insured. It supplements the insurance program by providing services in addition to those made available under the insurance provisions and by helping States provide medical services to persons under age 65.

MEDICAL CARE SERVICES

QUESTION 31

What medical services are included as "medical assistance"?

Answer: They will vary from State to State. As a minimum, the State must provide some institutional and some noninstitutional care. Because of the requirement that the full cost of any deductible imposed under the Federal insurance program shall be paid by the State agency for old-age assistance recipients, the State must also provide inpatient hospital services, outpatient hospital diagnostic services, and the first 3 pints of whole blood (if blood is not available to the patient from other sources). Since persons aged 65 and over will thus receive these three services, all persons in the State who are eligible for the medical assistance program must receive the same items, in the same amounts. This principle of equality is a special feature of the medical assistance program.

In addition, a State may include any or all of the 15 items identified in the Act (and listed under answers 33 and 34) as medical assistance care and services. By July 1, 1967, a State must include at least five basic services.

QUESTION 32

What is meant by "some institutional and some noninstitutional" care?

Answer: No precise definition of "some," in this context, is found either in the law or in the policies interpreting the law developed by the Welfare Administration of the Department of Health, Education, and Welfare. State plans that have been approved provide a sufficient number of days of hospital care to meet the needs of most people. They also provide, in general, noninstitutional care sufficient in amount, duration, and scope to promote health and provide treatment that will prevent the need for more expensive inpatient care.

QUESTION 42

The Act refers to medical assistance of "high quality." How can high quality be attained in a system that of necessity will vary significantly from State to State?

Answer: It is true that there will be State-to-State differences in the amount, duration, and scope of medical care and services. The high-income State may be able to provide practically all the services that anyone could need. For low-income States a medical assistance program may not be possible for some years. The middle-income State may be able to guarantee only a modest number of days of hospitalization, a limited number of physician's visits; it may be able to provide no dental services or eyeglasses. Differences among States in adequacy of financial assistance, medical assistance, and social services have characterized the grant-in-aid programs from the beginning. Nevertheless, the new legislation clearly calls for concerted efforts by both Federal and State administrators to develop a program that is sound, acceptable, and working towards excellence.

Even if a State's funds are so limited that, in the beginning, the program can reach only those persons eligible for financial assistance, the service provided can be of high quality. The fee structures for physicians can be set high enough to encourage the community's best practitioners to take part. The greater competence of men who are certified by a specialty Board or eligible for Board certification, or who are otherwise accepted by the medical community as qualified specialists in the field, should be recognized in the fee structure. This recognition will help ensure that eligible persons will receive medical care and services from specialists for conditions usually considered to require specialist attention, at least to the extent the general population of the community does. The State's Medical Care Advisory Committee, representing key professional groups, will be a potent factor in ensuring high quality.

Accommodations in hospitals may not be less desirable than the semiprivate ones assured patients under medicare—that is, two-bed, three-bed, or four-bed accommodations. Beginning July 1, 1967, hospital fees must be based on the reasonable cost of inpatient hospital services. All these measures and others, are designed to ensure high-quality care.

[U.S. Department of Health, Education, and Welfare] D-1100

Handbook of Public Assistance Administration
Supplement D
Medical Assistance Programs

Development of a Comprehensive Program

D-1100 6/17/66

D-1100. Development of a Comprehensive Program

Section 1903(e) of the Social Security Act reads as follows:

> "The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."

Section 1903(e), read in context with other statutory provisions related to program goals, effective administration, and quality of care, requires progressive steps in the direction of a comprehensive scope of medical care and services for families and individuals whose limited income and resources are insufficient to purchase them.

The law requires the Secretary, as a condition to continued payment of Federal grants-in-aid, to satisfy himself of State effort in this direction.

State effort must be evident in the following areas until appropriate goals are reached:

1. Strengthening of professional medical and supporting staff in the administration and supervision of the plan. (This includes an adequate number of staff, professional qualifications and arrangements for staff development.)

2. Broadening of scope of services made available.

3. Liberalizing of eligibility requirements to admit additional low-income families and persons to the program.

4. Intensifying social services focused on appropriate utilization of medical care and services, and on enabling recipients to attain or retain independence or self-care.

The law, as implemented by the policies in this Handbook Supplement, makes specific provision for progressive improvement in breadth and depth of the medical assistance program, quality of care and services, and adequacy of administration.

Handbook of Public Assistance Administration
Supplement D
Medical Assistance Programs

Amount, Duration, and Scope of Assistance

D-5100 4/3/67

D-5130. Criteria for the Administration of the Plan

1. The items of medical and remedial care and services which the State includes in its plan are sufficient in amount, duration, and scope reasonably to achieve their purpose.

2. Criteria to assure high quality of the care and services provided under the plan include the following:

a. Provision is made for use of specialist and consultative medical service.

b. Provision is made for necessary transportation of recipients to and from the suppliers of medical and remedial care and services.

c. Priority is given to the use of available semi-private accommodations (as defined in section 1861(v)(4) of the Social Security Act) for hospitalized recipients.

d. Long-term care of patients in medical institutions is provided in accordance with procedures and practices that include the following: [omitted]

e. Standards for medical and remedial care and services incorporate, as appropriate, standards in other specialized, high quality programs, particularly the program of crippled children's services.

f. In the provision of drugs,

(1) The State uses professional pharmaceutical consultation;

(2) Standards and procedures provide for dispensing of drugs at the lowest cost consistent with quality; and

(3) There is review and analysis of drug bills, including the compilation of statistics with respect to types, quantities, and cost of drugs dispensed.

g. There is a specific plan for a continuous evaluation of the utilization and quality of medical and remedial care and services provided under the State plan.

h. Methods exist that assure that direct service workers and their supervisors are knowledgeable about health problems and ways to assist people to secure medical and remedial care and services.

i. Direct service workers are kept currently informed of significant medical information concerning their clients.

3. The agency utilizes its staff and advisory committee to plan and promote broadening of the scope of medical and remedial care and services toward the goal of comprehensive care.

4. If the State plan includes medical and remedial care and services in relation to family planning, as defined in D-5141, item 15b, the agency's policies and procedures for staff, and practices thereunder, assure to individuals freedom from coercion or pressure of mind or conscience and freedom of choice of method, so that individuals can choose in accordance with the dictates of their consciences.

D-5140. Interpretation

The passage of title XIX marks the beginning of a new era in medical care for low income families. The potential of this new title can hardly be over-estimated, as its ultimate goal is the assurance of complete, continuous, family-centered medical care of high quality to persons who are unable to pay for it themselves. The law aims much higher than the mere paying of medical bills, and States, in order to achieve its high purpose,

will need to assume responsibility for planning and establishing systems of high quality medical care, comprehensive in scope and wide in coverage.

In a well-balanced program, whether or not the scope of services is comprehensive, institutional and non-institutional care should be mutually supportive, allowing the patient to move into the institution and back to the community according to his medical needs. A variety of non-institutional services is needed to assure continuity of care. A system which provides the patient with appropriate care when and where needed not only promotes quality but is also economical. For example, to provide physicians' services, but not drugs, is self-defeating, and costly in both human and fiscal terms.

The medical assistance made available must be sufficient in amount, duration, and scope reasonably to achieve its purpose. A token service which can only be ineffective on the one hand, and wasteful of funds on the other, will not be considered satisfactory. Institutional care should not be less in amount than would be required by most of the persons needing this kind of care. As an example, if a substantial number of persons admitted to hospitals required 21 or more days care per admission, the State's standard should not provide for a fewer number of days. In appraising the amount, duration, and scope of medical assistance to be provided, consideration will need to be given to the stage of development of the State's program and the availability of medical care and services in the State.

Non-institutional care should include medical services in amounts which will promote health and provide treatment to persons in lieu of more expensive inpatient care.

Limitations may not be set by eliminating certain groups of patients or certain diagnoses from coverage (except patients under 65 years of age in institutions for tuberculosis or mental diseases and patients under 21 in nursing homes). Neither may limitations be set by making eligibility for one kind of medical

care dependent on the receipt of another kind. For example, non-institutional care may not be limited to persons discharged from institutional care.

In addition to the items of medical and remedial care and services required to be included in the State plan (D-5120, items 1 and 2), any or all of the 15 items enumerated in section 1905(a) of the Act may also be included. These 15 items are defined below. In all these items, the following three definitions apply, except to the extent the context otherwise requires.

1. "Patient" is defined as an individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or alleviation of disability or pain.

2. "Inpatient" is a patient who has been admitted to a hospital, nursing home, or other medical institution on recommendation of a physician or dentist and is receiving room, board and professional services in the institution on a continuous 24-hour a day basis.

3. "Outpatient" is a patient who is receiving his professional services at an organized medical facility, or distinct part of such facility, which is not providing him with room and board and professional services on a continuous 24-hour a day basis.

D-5141. Definitions

1. *Inpatient Hospital Services (Other Than Services in an Institution for Tuberculosis or Mental Diseases)*

The term "inpatient hospital services" means those items and services ordinarily furnished by the hospital for the care and treatment of inpatients, which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by

an officially designated State standard-setting authority; and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under title XIX.

2. *Outpatient Hospital Services*

"Outpatient hospital services" are defined as those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution licensed or formally approved as a hospital by an officially designated State standard-setting authority; and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

* * * *

5. *Physicians' Services, Whether Furnished in the Office, the Patient's Home, a Hospital, a Skilled Nursing Home, or Elsewhere*

The term "physicians' services" is defined as those services provided, within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

* * * *

9. *Clinic Services*

"Clinic services" are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients.

D-5142. Expansion of Program

States which initially limit the scope of their program to the minimum of "some institutional and some non-institutional care" will be expected to proceed at once, through a series of planned steps, to expand the scope of care to cover the five basic services which are required by July 1, 1967. As soon as these five services have been covered, States will need to proceed with further expansion in order to reach the goal of comprehensive medical care by 1975. Comprehensive care includes all preventive, diagnostic, curative and rehabilitative services or goods furnished, prescribed or ordered by a recognized practitioner of the healing arts within the scope of his practice. It is expected that most States in the early stages of development under title XIX, will concentrate on the provision of diagnostic and curative services, but as expansion takes place, these services should be augmented with preventive and rehabilitative services. Since the areas of prevention and of rehabilitation are vast and largely unexplored by States, beginnings may be made by providing vaccination and inoculation services and selected screening procedures for certain conditions. As States gain experience in the provision of medical and remedial care and services, they should be able to make increasing use of the rapid advances in medical knowledge and skills in the field of rehabilitation.

D-5143. Equality of Medical Care

A basic concept of title XIX is that of equality of medical and remedial care and services. Its purpose is to erase the differences in the various categories in regard to care and services. What this means in actual operation is that AFDC children will be treated the same as all other recipients. In medical assistance, the categorically needy are considered one indivisible group, and the same services, in the same amount and quality, and of the same duration, must be made available to all within the group. The only exceptions are skilled nursing home services, which may be limited to persons age 21 or over,

and services to persons in institutions for tuberculosis or mental diseases which may be limited to the matchable group of persons age 65 or over.

Similarly, the medically needy are considered an indivisible group, and there must be equality in the amount, duration, and scope of medical and remedial care and services provided all persons within this group, with the exceptions noted above.

There need not, however, be equality between the two groups. That is, the care and services offered the categorically needy may exceed, but may not be less than, those offered the medically needy.

The principle of equality requires that the States provide inpatient hospital services, outpatient hospital diagnostic services, and the first three pints of whole blood, if not available from other sources, for all recipients, since the law requires that States, under title XIX, be responsible for meeting the deductibles imposed under part A of title XVIII.

D-5144. Quality of Medical Care

The Congress has made very clear its intent that the medical and remedial care and services made available to recipients under title XIX be of high quality and in nowise inferior to that enjoyed by the rest of the population. To make sure that the concept of quality is not lost sight of, the law requires the States to establish methods and standards to assure high quality care. In meeting this requirement, the State agency should look to its medical care advisory committee for help. This committee can also advise the State agency in planning utilization studies. The State agencies for Crippled Children's Services and Maternal and Child Health Services are other important resources in assisting the State agency to establish high standards of care.

In providing services which at least meet the specifications identified in the definitions contained in the foregoing part of

this seciton, States will be assured of sound basic quality. Beyond this, services of specialists need to be readily available. The State, in setting standards for specialists, should require that specialists, in order to participate in the program, be certified by the appropriate medical or osteopathic specialty board; or be qualified for admission to the examinations of the appropriate board; or hold an active staff appointment in a hospital approved for training in the appropriate specialty with privileges in that specialty. Dental specialists should be Board certified or Board eligible or otherwise recognized by a dental society of the State as a qualified specialist in the field.

A State which provides for the purchase of prostheses, appliances or aids should establish standards for the selection, fitting and training in the use of the devices. The standards should be formulated with the help of the medical care advisory committee, utilizing available standards such as those established under the State crippled children's services, physical restoration programs under Vocational Rehabilitation, etc.

Provision for paying the costs of transportation, determined by the agency to be necessary for obtaining medical care and services, is an important factor in achieving both equality of care and high quality of care. Recipients who live at a distance from the supplier of medical service may need assistance in meeting the costs of transportation. Assurance that transportation costs will be met also assures that the services of specialists and facilities of high quality throughout the State and outside the State are available as needed to all recipients, and eliminates reliance on inferior resources.

In order to secure a high quality of medical and remedial care and services, it will be necessary for States to establish realistic schedules of compensation for services, which should be commensurate with "reasonable cost" or "reasonable charge" and not inconsistent with prevailing community payments, such as those under title XVIII or Blue Shield plans.

The purpose of a title XIX program is to get medical care without delay to eligible people who need it. In fulfilling this purpose, the local caseworker is a key figure. Both caseworkers and their supervisors must be sensitive to and informed about medical problems and how to assist individuals and families to get the care necessary, as well as how to work with social problems related to medical problems. The caseworker is in a unique position to assist the medical disciplines to avoid the waste, both human and financial, of fragmented, haphazard medical care. Through his knowledge of the family and of the individual, he can promote the realization of the goal of planned, total family-centered care. This means that all the factors which militate against the well-being of the recipient, both as an individual and as a family member, are dealt with in a planned, purposeful way. It means that all needed supportive services are brought to bear and coordinated in a unified effort between the health professions and the agency.

D-5150. Federal Financial Participation

Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the definitions, items 1 through 15, in D-5141 (also see D-5800).

Drugs.—With respect to "prescribed drugs," as defined in D-5141, item 12a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof.

Federal financial participation in expenditures for care and services for patients in institutions for tuberculosis or mental diseases is limited to persons 65 years of age or over.

Title XIX—STATE PLAN—LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES

STATE: Georgia **Attachment 3.1A**
Page 2a

Effective 8-1-75

LIMITATIONS:

5 PHYSICIANS' SERVICES

A. The Medicaid Office has developed a prior approval mechanism through the Georgia Medicaid Administration by at least one week prior to the provision of service for those physicians who *wish* to prior authorize a treatment plan. If a physician receives prior approval for a treatment plan, the subsequent claims will not be subject to retrospective peer review and possible denial. Any of the following *may* be submitted for prior approval.

1. Home or office visits in excess of one (1) per month.

2. More than one (1) referral of a recipient to a consulting physician in one month.

3. Outpatient hospital visits in excess of one (1) per month.

4. More than one (1) visit per month to a recipient in a skilled nursing facility or intermediate care facility.

5. Any service identified in The Georgia Medicaid Policy and Procedures Manual for Physician Services which requires additional documentation with the claim.

6. Any service identified in The Georgia Medicaid Policy and Procedures Manual for Physician Services which is identified for automatic peer review.

B. The following *must* be submitted for prior approval.

1. T & A, unless medical necessity does not provide sufficient time for approval. In those cases, the claim will be subject to peer review.

2. Removal of keloids, unless medical necessity does not provide sufficient time for approval. In those cases, the claim will be subject to peer review.

3. Osteopathic manipulative therapy (OMT).

4. Physical therapy which exceeds three treatments per week for eight weeks or a total of 24 treatments.

5. Services which are otherwise excluded by policy and procedure but are allowed under Georgia law.

C. Home, office, outpatient hospital, or nursing home visits are limited to one per month with the following exceptions; a medical emergency or acute illness exists; additional visits are required related to the original primary diagnosis chronic cases; or the primary care physician refers the recipient to needed specialist(s) for additional visit(s).

C. Medcosonolator rendered by the physician—payment will made of 1 daily for 5 days for mild inflammatory conditions if prior approval is given by Medicaid Administration prior to rendering of services.

D. Medcotherm rendered by the physician—payment will only be made for treatment 5 times a month for no more than 3 months if prior approval is given by Medicaid Administration prior to rendering of services.

E. Reimbursement will be limited to the following unless prior approval is obtained from the Medicaid Director at least one week prior to rendering service.

1. Vitamin B12 injections only in the treatment of Pernicious Anemia and Malabsorption Syndrome.

2. ACTH injections only in the treatment of Pituitary Insufficiency or Ulcerative Colitis.

3. Gonadatropin injections only in diagnoses other than obesity.

4. Pyralgin injections only for treatment of febrile convulsions of children when other medications have been found to be ineffective or in malignant diseases when fever cannot be controlled by any other means.

5. Antibiotic injections only when given on a rigid treatment regimine.

F. One urinalysis on the initial office visit, regardless of the diagnosis. Thereafter, urinalysis will not be allowed unless it is directly related to the diagnosis.

G. The Medicaid Program will not provide reimbursement for more than one physician inpatient hospital visit per day to a recipient unless a medical necessity exists. Physicians may request prior approval for additional visits. Clarifications are noted in the Ga. Medicaid Physicians Policy and Procedures Manual.

H. Cosmetic Surgery—Dermabrasions, hair transplants, face lifts, Ileo-bypass procedures for weight reduction, scars, Rhinoplasty—are not covered.

I. No reimbursement will be made for experimental surgery, e.g., trans-sexual operations.

J. Outpatient psychotherapy is limited to a maximum of $250 per patient per calendar year.

Eyeglasses, optical services and contact lenses provided for eligible recipients 21 years of age and over where both the visual examination was completed and a prescription for eyeglasses or contact lenses written prior to March 29, 1975; if such services were rendered under the policies and in conformity with the State Plan.

Prostetic lenses and related services are covered for all eligible recipients. This would include the provision of eyeglasses or contact lenses, as appropriate to an individual lacking the organic lens of the eye because of surgical removal or congenital absence.

6. PODIATRY SERVICES

A. The Medicaid Program will not provide reimbursement for a Podiatrist for more than one home, outpatient hospital, or office visit per month for a recipient unless the provider has received prior approval.

B. The Medicaid Program will not provide reimbursement for more than one inpatient hospital podiatrist visit per day to a recipient unless the podiatrist has received prior approval.

C. The Medicaid Program will not provide reimbursement for the following services of a podiatrist:

1. *Flatfoot*—The evaluation or nonsurgical treatment of a flatfoot condition regardless of the underlying pathology.

2. *Subluxation*—The evaluation of subluxation of the foot and nonsurgical measures to correct the condition or to alleviate symptoms.

3. *Routine Foot Care*—Routine foot care for ambulatory or bedridden patients includes, cutting or removal of corns, warts, or callouses, the trimming of nails and other hygenic and preventive maintenance care in the realm of self-care such as cleansing and soaking, the use of skin creams.

4. *Supportive Devices*—Orthopedic shoes other than shoes that are integral part of a brace and arch supports. An orthopedic shoe that is built in a leg brace is reimbursable. Biomechanical orthotics are not reimbursable.

Title XIX—STATE PLAN LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES

STATE: Kansas **Attachment 3.1A**

Effective 10-1-78

3.1A Limitation

 # 1. Inpatient Hospital Services

3.1-A Limitation

#1. Inpatient Hospital Services

All out-of-state inpatient care is subject to prior authorization except for emergency care and care within hospitals in Texas, Colorado, Nebraska, Oklahoma, Missouri, Iowa, and Arkansas, whose services are routinely utilized by Kansas recipients. No payment will be made for inpatient admissions from midnight Thursday through midnight Saturday, except in the case of an emergency admission. Any procedure which can be completed within a twenty-four (24) hour period is excluded from the nonadmission policy of Thursday midnight through Saturday midnight. Inpatient stays longer than the 50th percentile require written information confirming medical necessity.

Abortions are covered when necessary because the life of the mother is endangered if the fetus is carried to term, or when performed upon a victim of rape or incest and it has been reported to appropriate authorities within 60 days of the incident. Required documentation must be attached to all claims submitted.

Abortions will not be covered which would result in severe and long-lasting physical health damage to the mother if the pregnancy were carried to term.

Inpatient hospital stays for substance abuse treatment will not be covered unless provided in a treatment program certified by the drug and alcohol abuse section of SRS.

3.1-A Limitation

#5. Physician's Services

Hospital visits are not to exceed those allowable days for which the hospital is paid. Office visits are limited to three per month unless supported by written documentation confirming medical necessity. Adult Care Home visits are limited to one per month unless supported by written documentation confirming medical necessity. Office visits for psychiatric services are limited to three per month unless supported by written documentation confirming medical necessity. Medical necessity for mental, emotional and behavioral conditions shall be defined "likely to do physical injury to himself, herself, or others", or for recipients needing psychiatric care in situations not life-endangering but medically necessary more often than three (3) times monthly, prior authorization is needed. Surgery for cosmetic purposes is not payable.

Services to the hard of hearing are limited to ear examination by the physician and testing of hearing acuity by the physician ear specialist.

Abortions are covered when necessary because the life of the mother is endangered if the fetus is carried to term, or when performed upon a victim of rape or incest and it has been reported to appropriate authorities within 60 days of the incident. Required documentation must be attached to all claims submitted.

Abortions will not be covered which would result in severe and long-lasting physical health damage to the mother if the pregnancy were carried to term.

State: Kentucky

Attachment 3.1A
Page 7.2

	Service	Categorically Needy	Medically Needy
5.	Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere	Provided PA* ☐ No limitations ☒ With limitations*	☒ Provided PA* ☐ No limitations ☒ With limitations* ☐ Not provided
6	Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law		
	a. Podiatrists' Services	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
	b. Optometrists' Services	☒ Provided PA* ☐ No limitations ☐ With limitations* ☐ Not provided	☒ Provided PA* ☐ No limitations ☐ With limitations* ☐ Not provided
	c. Chiropracters' Services	☐ Provided ☐ No limitations ☐ With limitations ☒ Not provided	☐ Provided ☐ No limitations ☐ With limitations* ☒ Not provided
	d. Other practitioners' Services	☒ Provided (Identified on attached sheet with description of limitations, if any) ☐ Not provided	☒ Provided (Identified on attached sheet, with description of limitations, if any) ☐ Not provided

* Description provided on attached sheet.

Effective 4-1-76

5. Physician's Services (Limitations apply to both categories)

A. Coverage for certain initial and extensive visits is limited to two visits per patient per physician per calendar year. This limitation applies only to the following specific procedures:

9000	INITIAL office visit, ROUTINE, new patient or new illness, history and examination.
9001	INITIAL (or subsequent) office visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT OR MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs.
9002	INITIAL (or subsequent) office visit, COMPLETE, diagnostic history and pnysical examination, NEW PATIENT OR MAJOR ILLNESS, including initiation of diagnostic and treatment programs.
9006	FOLLOW-UP office visit, PROLONGED, over and above 9005.
9007	FOLLOW-UP office visit necessitating COMPLETE reexamination and re-evaluation of patient as a whole (continuing illness).
9010	INITIAL home visit, ROUTINE, new patient or new illness, history and examination.
9011	INITIAL home visit, COMPLETE diagnostic history and physical examination, ESTABLISHED PATIENT or MINOR CHRONIC ILLNESS, including initiation of diagnostic and treatment programs.
9012	INITIAL home visit, COMPLETE diagnostic history and physical examination, NEW PATIENT or MAJOR ILLNESS, including initiation of diagnostic and treatment programs.

B. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per calendar year.

C. Coverage for laboratory procedures performed in the physician's office is limited to those procedures listed on the physician's laboratory benefit schedule.

D. Pre-authorization is required for those patients, "locked in" to one physician and one pharmacy, who require services in excess of 4 prescriptions and four physicians office visits per month.

E. The cost of preparations used in injections is not covered.

F. Physician—patient telephone contacts are not covered.

Effective 1-1-79

Abortion service are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of a physician, necessary for the preservation of the life of the woman seeking such treatment. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed; and such certification must also indicate the procedures used in providing such services. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

6. Medical Care and Any Other Type of Remedial Care

b. *Optometrists' Services* (Limitations apply to both categories)

1. *Optometric Benefits*

a) Optometric benefits are limited to eligible recipients under the age of 21.

2. *Vision Care Service*

a) Coverage is limited to those procedures listed on a benefit schedule for vision care services. These procedures are included in the following categories:

1) Diagnostic Services

2) Prescription Services

3) Services to frames and lenses

b) All eyeglasses, other than those prescribed for amblyopic or post-surgical patients, must be pre-authorized by the Program.

c) Pre-authorization is also required for certain replacement of frames and lenses, and/ or replacement of parts.

State: VERMONT **Submittal No.: 79-22**
ATTACHMENT 3.1-A
Effective 1-1-80 **Page 2a**

Item 5. Physicians' Services

A. Physician's services for treatment of mental, psychoneurotic or personality disorders, as defined in the American Psychiatric Association's "*Diagnostic And Statistical Manual* —Mental Disorders", are limited to a maximum of $500.00 in a calendar year. This limitation does not apply to physicians' services provided while the individual is a hospital inpatient, nor to home health, mental health clinic, and hospital outpatient services.

Extensions to the $500.00 limitation may be granted if there are compelling reasons to do so; e.g., abrup termination of treatment would place the recipient in serious and immediate jeopardy, discontinuation of care would substantially cancel improvement in the patient's mental condition, or no alternative mode of treatment is available. Requests for extensions must include the medical and psychiatric history of the patient, recommended course of treatment, anticipated number and frequency of services, and such other relevant information as will fully substantiate the request.

B. Physician services directly related to experimental treatment procedures are specifically excluded. The following types of organ transplants are considered to be experimental treatment procedures and, therefore, not covered: heart, lung, spleen, liver, pancreas, endocrine organs, brain, stomach, eye, appendages, thymus.

C. Reimbursement can be made for one physician visit to the same recipient in a nursing home (not an ECF) in a calendar month on the presumption that such a visit is medically necessary for the proper management of a person whose condition requires him to reside in such a home. Further visits

are reimbursable only if the claim submitted by the physician has adequately substantiated the need for more frequent visits to the patient.

Where it is established that a physician visited only one patient on a particular trip to a nursing home, reimbursement will be based on an amount which may not exceed the normally applicable customary and prevailing charge for routine follow-up house calls. Since this level of reimbursement already takes into account that the physician may have some additional expense in terms of travel to the nursing home and time away from his office, no additional charge will be recognized except in extraordinary circumstances. All other claims will be treated as multiple visit situations and the reasonable charge allowance will be based on the customary and prevailing charges for routine follow-up office visits.

D. Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery encompasses any surgical procedure directed at improving appearance (including removal of tattoos), except when required for the prompt repair of accidental injury or the improvement of the functioning of a malformed body member. For example, the exclusion does not apply (and payment would be made) for surgery in connection with treatment of severe burns or repair of the face following an auto accident, or for surgery for therapeutic purposes which coincidentally serves some cosmetic surgery should be requested from the Department's consulting physician.

E. Sterilization of either a male or female recipient is covered only when the following conditions are met:

1. The recipient has voluntarily given informed consent and has so certified by signing the consent form included in DHEW Publication No. (OS)79-50061 (female), or (OS)79-50062 (male), November, 1978 and provided by the Department of Social Welfare.

2. The recipient is not mentally incompetent.

3. The recipient is at least 21 years old at the time consent is obtained.

4. At least 30 days but not more than 180 days have passed between the date of informed consent and the date of sterilization except in the case of premature delivery or emergency abdominal surgery. In those cases, at least 72 hours must have passed between the informed consent and the operation.

Operations or procedures performed for the purpose of reversing or attempting to reverse the effects of any sterilization procedure are not covered.

F. A hysterectomy is not covered if:

1. It was performed solely for the pupose of rendering an individual incapable of reproducing.

2. There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Any other hysterectomy is covered only if the recipient has been informed as to the nature of the operation and its consequences and has given consent by signing the Hysterectomy Consent Form (DSW 219C).

G. Providers will be reimbursed by Medicaid for abortions performed only if:

1. A physician, on the basis of professional judgement, has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term.

2. Two physicians, at least one of which has neither direct nor indirect financial interest, on the basis of their

professional judgment, have certified in writing that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term.

3. Such procedures are for a victim of rape or incest when such rape or incest was reported within 60 days of incident to a law enforcement agency or public health service, and such report is documented to the Department.

4. The abortion is performed to terminate an ectopic pregnancy.

H. Routine payment will not be made for the following procedures. Written justification will have to be made by the physician and approved by the Division of Medical Services before payment will be authorized. The procedures were identified because each fits into one or more of four specific categories:

1. New procedures of unproven value.

2. Established procedures of questionable current usefullness.

3. Procedures which tend to be redundant when performed in combination with other procedures.

4. Diagnostic procedures which are unlikely to provide a physician with additional information when they are repeated.

Identification of these procedures was made through the Medical Necessity Program begun by Blue Shield with the assistance of the American College of Physicians, American College of Radiology and American College of Surgeons. Also participating, was the American Academy of Family Practice, Council of Medical Specialties, American Hospital Association and American Association of Medical Colleges.

The surgical procedures are:

1. Ligation of internal mammary arteries, unilateral or bilateral—the tying of the mammary arteries located in the chest.

2. Radical hemorrhoidectomy, whitehead type—extensive surgical excision of hemorrhoids.

3. Omentopexy (portal obstruction)—surgical fastening the omentum (a tissue extending from the stomach to other organs in the abdomen) to establish a more efficient blood flow between the stomach/intestines and spleen through (via) the liver.

4. Kidney decapsulation, unilateral and bilateral—the surgical removal of a fatty or fibrous structure which covers all or part of the kidney.

5. Perirenal insufflation—injecting air around the kidneys for x-ray visualization of the adrenal glands, located on top of the kidneys.

6. Nephropexy—the fixation or suspension of a floating (not attached) kidney.

7. Circumcision, female—the incision of the fold of the skin over the clitoris.

8. Hysterotomy—cutting into the uterus for non-obstetrical reasons from the vaginal approach.

9. Supracervical hysterectomy—the uterus is removed, leaving the cervix in place. In addition, the ovaries and/or fallopian tubes may be removed.

10. Uterine suspension—the fixation of suspension of the uterus to the vagina or abdominal wall by shortening ligaments attached to the uterus.

11. Uterine suspension with presacral sympathectomy—same as above but with the interruption of the sympa-

thetic nerve pathways in front of the sacrum. The sympathetic nervous system stimulates, among other parts, the reproductive system. The sacrum is the bone located just below the lower back region and is composed of a series of fused vertebrae.

12. Hypogastric or presacral neurectomy—the excision of part of the hypogastric or presacral nerve (plexus).

13. Fascia lata by stripper when used to treat lower back pain—the repair of the sheath of connective tissue which covers or binds body structures together.

14. Fascia lata by incision when used to treat lower back pain—same as above, but the fascia is incised and removed.

15. Ligation of femoral vein, unilateral and bilateral when used to treat post-phlebitic syndrome—the tying of the famoral vein in the thigh for post phlebitic syndrome (post-thrombotic (clot) complication which includes, but is not limited to destruction of the valves of the deep veins of the legs).

16. Excision of carotid body tumor when used to treat asthma—the removal of a round mass located on or near the carotid artery in the neck.

17. Sympathectomy, thoracolumbar, unilateral or bilateral when used to treat hypertension—the interruption of some portion of the sympathetic nerves in the back.

18. Angiocardiography, multiplane supervision and interpretation only in conjunction with cineradiography. This is similar to 17. above except x-rays are taken from more than one angle.

19. Angiography-coronary, unilateral, selective injection, supervision and interpretation only, single view

unless in an emergency. This procedure photographs the coronary arteries of the heart. It uses a single view x-ray after an injection of a radiopaque substance. It is used on coronary patients or as a diagnostic test to determine the conditions of the coronary vessels.

20. Angiography extremity. This procedure photographs the arteries of the arms and legs. The test is used to determine the presence of clots, ruptures or constrictions in the arteries.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

ARTHUR F. QUERN, Director Illinois Department of Public Aid, *et al.*,

Appellants,

vs.

DAVID ZBARAZ, M.D., *et al.*,

Appellees.

On Appeal from the United States District Court for the Northern District of Illinois

AMICUS CURIAE BRIEF OF THE STATE OF NEW JERSEY

JOHN J. DEGNAN,
Attorney General of New Jersey,
Attorney for the State of New Jersey,
State House Annex,
Trenton, New Jersey 08625.

ERMINIE L. CONLEY,
Assistant Attorney General,
Of Counsel.

ANDREA M. SILKOWITZ,
Deputy Attorney General,
On the Brief.

Adams Press Corp., 5 Commerce Street, Newark, N. J. 07102—(201) 623-8611

TABLE OF CONTENTS

Cases Cited

United States Constitution Cited

New Jersey Constitution Cited

Statutes Cited

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-5

ARTHUR F. QUERN, Director Illinois Department of Public Aid, *et al.*,

Appellants,

vs.

DAVID ZBARAZ, M.D., *et al.*,

Appellees.

On Appeal from the United States District Court for the Northern District of Illinois

AMICUS CURIAE BRIEF OF THE STATE OF NEW JERSEY

Interest of the *Amicus*

The State of New Jersey is filing a separate *amicus curiae* brief in this matter because the Court's action will have a direct and crucial impact on the necessary flexibility the State's legislative and administrative officials

must be afforded to fashion with limited fiscal resources a medical assistance program providing services deemed most responsive to competing public needs. The decisions of the United States District Court for the Northern District of Illinois and the Seventh Circuit Court of Appeals, as well as other similar decisions which have read far-reaching requirements with respect to allocation of medical assistance funds into the Equal Protection Clause of the Fourteenth Amendment and Title XIX of the Social Security Act, promise to substantially undermine the broad discretionary powers a State must have to fashion welfare programs attuned to the immediate local climate and responsive to competing needs of the poor.

Although New Jersey's limited fiscal resources do not permit it to provide every desirable public assistance service, New Jersey has attempted to provide a sound and publicly acceptable welfare assistance program for medical services by balancing the complex and competing needs of the poor to satisfy the most urgent and necessary of these needs. Thus, in terms of medical assistance the State has, for the present, chosen to provide for those services which it deems medically necessary. In extending such assistance for such controversial services as abortions, the State has followed this present policy and authorized, by Laws of 1975, Chapter 261 (N.J.S.A. 30:4D-6.1), assistance for the termination of a women's pregnancy where "it is medically indicated to be necessary to preserve the woman's life."

Since enactment of that law, the State has been embroiled in almost continuous litigation as to the constitutionality of the coverage policy: initially in federal district court litigation (*Doe* v. *Klein,* Civil Action No. 76-64, ultimately dismissed on the basis of *Maher* v. *Roe,* 432 U.S. 464 (1977); and now in a multifaceted suit pending

in the Superior Court of New Jersey, Chancery Division, (*Right to Choose* v. *Byrne*) in which the plaintiffs have challenged the validity of N.J.S.A. 30:4D-6.1 on the same constitutional and statutory bases raised below in this case. As a result of that litigation, this statutory reimbursement policy has been voided as inconsistent with the alleged mandate of Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.* to provide coverage for necessary medical services. *Right to Choose* v. *Byrne,* 165 N.J. Super. 443, 398 A. 2d 587 (Ch. Div. 1979). In accordance with that decision, State administrative officers proposed new guidelines for Medicaid coverage of abortions mirroring the conditions for reimbursement set forth in Pub. L. 95-480, 92 Stat. 1586 (the federal fiscal year 1978 "Hyde Amendment"). In an opinion issued on July 3, 1979 the State court ruled that the failure of the guidelines to provide coverage for all medically necessary abortions violated plaintiffs' "fundamental right" to public benefits for the protection of health "[s]hielded by the Fourteenth Amendment to the Federal Constitution and by Article I, paragraph 1 of the [New Jersey] Constitution against unreasonable and discriminatory restriction . . .", *Right to Choose* v. *Byrne,* 169 N.J. Super. 543, 551-552, 405 A.2d 427, 431-432 (Ch. Div. 1979), thus reaching the same result as was reached in this case by the District Court below. As a result of this decision and Congress' recent resolution barring utilization of federal funds for Medicaid abortions, except in cases of rape and incest and where necessary to preserve the mother's life (H.J.Res. 440), the State will be compelled to provide, in most cases at wholly state expense, Medicaid funds for all abortions deemed medically necessary by a recipient's physician.

Any decision therefore by this Court in the present case will substantially, if not conclusively, determine the outcome of the State's ultimate appeal from the trial court's

ruling in *Right to Choose* v. *Byrne* and the validity of N.J.S.A. 30:4D-6.1. It is clear therefore, that the State of New Jersey has a vital interest in preserving the prerogative of its Legislature to fashion reasonable provisions for such controversial public welfare assistance consistent with the Legislature's views of proper allocation of State resources.

ARGUMENT

POINT I

A legislative decision to deny Medicaid coverage for abortions which are not prompted by life-threatening health concerns advances significant interests of the State and thus comports with the requirements of the Equal Protection Clause of the Fourteenth Amendment.

The ultimate constitutional issue involved in this case is whether equal protection of the law under the Fourteenth Amendment inflexibly mandates governmental officials to allocate public resources for all abortions deemed medically necessary by a physician, irrespective of the gravity of the precipitating health condition, when that government has elected to extend coverage for all other medically necessary services without limitation. As the court below properly recognized, in the aftermath of *Maher* v. *Roe*, 432 U.S. 464 (1977), such a funding limitation cannot be perceived as infringing upon the fundamental right to choose to terminate a pregnancy nor as violating any constitutionally imposed mandate that would require a state to extend medical assistance to the indigent. *Id.* at 469. As with the Connecticut regulation reviewed in *Maher* v. *Roe*, this more restrictive funding limitation "places no obstacles—absolute or otherwise—in the pregnant woman's

path to an abortion . . . she continues as before to be dependent on private sources for the service she desires." In so doing, "[t]he State may have made childbirth a more attractive alternative, thereby influencing the woman's decision, but it has imposed no restriction on access to abortions that was not already there." *Id.* at 474. Thus, as in *Maher*, the validity of the funding distinction challenged herein must be judged not under the more exacting scrutiny reserved for State actions impinging upon fundamental rights or creating suspect classifications, but under the more lenient "rational basis" test. If then the governmental decision to fund only those medically necessary abortions prompted by life-threatening health concerns is "rationally related to a constitutionally permissive purpose", the State's action in distinguishing between abortion and other medical services must be upheld. *Id.* at 478.

In this respect, a party who challenges the validity of social legislation under the Equal Protection Clause of the Fourteenth Amendment generally bears the heavy burdent of overcoming the strong presumption of constitutionality attendant to such legislative action. *Jefferson* v. *Hackney*, 406 U.S. 535, 546-547 (1972). As the Court has repeatedly recognized "[s]o long as its judgments are rational and not invidious, the legislature's efforts to tackle the problems of the poor and the needy are not subject to a constitutional straitjacket." *Ibid.* Particularly in an area such as abortion funding which arouses such intense intellectual, moral and emotional confrontations, the court's function is not to judge the "wisdom or social desirability" of the ultimate policy judgment, *Maher* v. *Roe, supra* at 479, but whether the balance struck is a reasonable one. *Dandridge* v. *Williams*, 397 U.S. 471, 483-486 (1970). The manner in which state welfare funds are

to be expended is a discretionary responsibility of each state, which cannot be disturbed "unless the choice is clearly wrong, a display of arbitary power, [and] not an exercise of judgment." *Mathews* v. *deCastro,* 429 U.S. 181, 185 (1976).

Thus, in *Maher* v. *Roe, supra* the Court upheld the prerogative of legislators to foster the state's "strong and legitimate interest in encouraging normal childbirth" by subsidizing the full costs of childbirth and denying payment for medically unnecessary abortions. While recognizing the difficult plight this policy presented to indigent women who desired to terminate their pregnancy, the Court emphasized that the Constitution did not require any "judicially imposed resolution" of this social problem. On identical grounds in *Poelker* v. *Doe,* 432 U.S. 519 (1977) the Court upheld the right of the City of St. Louis' hospitals to elect to perform only these abortions where there was a "threat of grave physiological injury or death to the mother."

Equally pertinent to this case is the Court's decision in *Gedulig* v. *Aiello,* 417 U.S. 484 (1974). Reaffirming the wide discretion accorded states in the fashioning of appropriate welfare programs, this Court rejected a challenge on equal protection grounds to the provisions of the California employment disability legislation which excluded coverage for pregnancy related disabilities. Recognizing the legitimate concerns of the states in attempting to provide sound programs with limited resources for as many people as possible, the Court upheld the exclusion despite the fact that the California program provided coverage for the full range of other medical disabilities.

The distinction made in the present case between medically necessary abortions not occasioned by life threatening health conditions and all other medical services is

no less a valid exercise of the State's powers to fashion appropriate welfare programs. While it is conceivable as the district court ruled below that this funding limitation may "increase substantially maternal morbidity and mortality among indigent pregnant women" it does not follow, as the court below concluded, that the State's critical interest in preserving potential human life is thereby overborne or rendered irrational. These are precisely the type and kind of choices the Legislature should be free to make.

Indeed in light of the unique consequences of the abortion procedure, it would be reasonable for a state to conclude as a matter of policy not to fund any abortions whatsoever. Rather than adopt such an absolute and unwavering approach, Illinois has struck what its legislators believe to be a humane and reasonable compromise —of acquiescing in the performance of an abortion with public funds only when the mother's life is in jeopardy. That the legislature might have defined more broadly the situations in which maternal health concerns would outweigh fetal life is clear. However, its failure to acquiesce in that policy judgment does not render its decision unsound or an improper exercise of legislative power.

As set forth in the interest of the *amicus* portion of this brief, the duly elected representatives of the New Jersey Legislature, like the Illinois Legislature, have determined to allocate limited public funds to provide assistance for necessary medical services, including abortions required for life-threatening medical conditions, prenatal and other medically necessary childbirth care. This judgment involves areas of controversy primarily entrusted to state government. While the compromise struck by these representatives may not be compatible with individual social concerns, it must be remembered that "the Fourteenth

Amendment gives the federal courts no power to impose upon the States their views of what constitutes wise economic or social policy." *Dandridge* v. *Williams, supra* at 486. For this reason, the ruling of the District Court below must be reversed.

POINT II

Title XIX of the Social Security Act authorizes states participating in the federally funded medical assistance program to make judgments based upon significant fiscal, medical and moral concerns as to which medical services will be covered and thus would not preclude in view of the strong state interest in protecting potential fetal life the provision of Medicaid funding solely for those abortions necessary to preserve the life of the mother.

Although the District Court's order below focused on the constitutionality of the federal and Illinois limitation on funding for Medicaid abortions, its order necessarily incorporates the court's previous injunction, as modified by the Seventh Circuit Court of Appeals, that the Illinois statute's funding limitation was not in conformity with the requirements of Title XIX of the Social Security Act because it provided a more limited category of Medicaid funded abortion services. Thus, were this Court to reverse the District Court's constitutional ruling, Illinois nevertheless would be precluded from enforcing its legislatively approved abortion policy and would be required to abide by whatever policy judgments are made by Congress. Since, as a practical matter therefore, the injunction would enforce the prior ruling of the Seventh Circuit and since the Illinois Legislature has not acted to repeal its more limited statutory Medicaid program, review of the underlying Supremacy Clause issue by the Court would be appropriate. See *Quern* v. *Mandley*, 436 U.S. 725, 739 (1978).*

* Additionally the Court's review of the issue of State discretion under Title XIX to determine whether a service is medically necessary and to deny coverage for certain necessary medical treatment within mandated coverage areas is imperative in order to resolve the conflicting interpretations of the statute by federal and state judiciary and the federal Department of Health, Education and Welfare (HEW). Thus, the federal District Court in *Roe* v. *Casey*, 464 F.Supp. 487, 500-502 (E.D. Pa. 1978) has interpreted this Court's characterization of the issue in *Beal* v. *Doe*, 432 U.S. 438, 444 (1977) as raising "serious statutory questions" as a definitive ruling by this Court that State discretion in establishing the parameters of a medical assistance program extended only so far as to allow exclusion or limitation of unnecessary medical services. *Id.* at 501. Again, in *Rush* v. *Parham*, 440 F. Supp. 383 (N.D. Ga 1977), app. pending *sub nom Rush* v. *Poythress*, No. 77-2743 (5th Cir), the court, in invalidating a ban on reimbursement for transsexual surgery, similarly relied upon the *Beal* decision in concluding that "Medicaid coverage is not optional or discretionary for necessary medical treatment of eligible recipients." *Id.* at 389. Additional rulings by state and federal courts, though not finding this Court's *Beal* v. *Doe* ruling dispositive, have interpreted governing federal statutory and regulatory provisions as mandating coverage of all medically necessary services. See *Doe* v. *Busbee*, 471 F.Supp. 1326 (N.D. Ga. 1979); *State* v. *Monmouth Medical Center*, 80 N.J. 299, 403 A.2d. 487 (S.Ct.), *cert.* denied —— U.S. —— (1979); *G.B.* v. *Lackner*, 80 Cal.App. 3d. 64, 145 Cal Rptr. 555 (Ct.App. 1978); *Doe* v. *Minnesota Department of Public Welfare*, 257 N.W. 2d. 816 (Minn. S.Ct. 1977). Contrary readings of the statute however have been adopted. Thus in *Virginia Hospital Association* v. *Kenley*, 427 F. Supp. 781 (E.D.Va.1977) the Court found persuasive HEW's interpretation of Title XIX as authorizing a State Medicaid program's exclusion of coverage of medically necessary inpatient hospital services provided beyond a 21 day limit. Similarly, in *Commonwealth of Pennsylvania Dept. of Public Welfare* v. *Temple*

(Footnote continued on following page)

The determination of the Seventh Circuit Court of Appeals raises what has become an increasingly frequent issue before the Court and other federal and state courts: ascertainment of the proper interplay between federal mandate and state prerogative in a public assistance program developed and funded through cooperative federalism. The specific issue presented—state discretion to set priorities for coverage of medically necessary services—poses the precise question left unresolved in *Beal* v. *Doe*, 432 U.S. 438, 444 (1977), namely the "serious statutory questions . . . presented if a State Medicaid plan excluded necessary medical treatment from its coverage. . . ." The Seventh Circuit Court of Appeals in this matter, adopting the analysis of the First Circuit Court of Appeals in *Preterm, Inc.* v. *Dukakis*, 591 F.2d 121 (1st Cir.), *cert.* denied U.S. (1979), properly concluded initially

(Footnote continued from preceding page)

University, 21 Pa. Commw. Ct. 162, 343 A.2d. 701 (Commw. Ct. 1975) the court upheld the State's denial of medically necessary inpatient hospital coverage beyond 60 days as consistant with the Act. Of particular pertinence herein is the ruling in *D--- R---* v. *Mitchell*, 456 F.Supp. 609 (D. Utah 1978), finding an abortion funding limitation identical to Illinois' consistent with Title XIX requirements. See also *Preterm, Inc.* v. *Dukakis*, 591 F.2d. 121, 125 (1st Cir.), *cert.* denied U.S. (1979).

It is apparent therefore that since the issuance of the *Beal* decision over two years ago, state and federal courts throughout the country have repeatedly grappled with the significant question left open by that decision: the extent of state discretion under Title XIX to deny Medicaid coverage for some medically necessary services. The many conflicting opinions rendered by these courts and particularly those in which HEW approved State plan amendments have been invalidated has created great confusion nationally as to the terms of state participation in the Medicaid program. The time is ripe therefore for the Court's consideration and determination of this question.

that the appropriations section of Title XIX (42 U.S.C. §1396), which authorizes the expenditure of federal money for the purpose of providing medical assistance to indigent persons for the costs of "necessary medical services", did not impose upon any participating state a substantive requirement of coverage for all medically necessary procedures (Aa5; *Preterm, Inc.* v. *Dukakis, supra*, at 124-125). Notwithstanding this recognition of the discretion Congress intended to afford the states in fashioning a medical assistance program, both the First and Seventh Circuit Courts of Appeal nevertheless proceeded to construe an additional provision of Title XIX, 42 U.S.C. §1396a (a) (17), which requires the establishment of "reasonable standards . . . for determining the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX]" and interpretative regulations of HEW, 42 C.F.R. §440.230, as in effect precluding states from exercising any discretion as to the coverage of medically necessary procedures. In reliance upon these provisions, it was concluded that no "rational social objective" would be served by a limitation upon medical assistance for abortion services beyond that imposed by Congress and that therefore a statutory program which limited Medicaid funding to abortions necessary to preserve the life of the mother was inconsistent with Title XIX, as amended by the Hyde Amendment. *Id.* at 126.*

In concluding that Title XIX precludes any limitation of abortion coverage other than that imposed by Congress and thereby removing from state elected officials the discretion to fashion a medical assistance program it deems most attuned and responsive to the particular needs and competing demands of its poor, these courts have miscon-

* Herein the courts concluded that the Congressional definition of an appropriate level of coverage would be the standards adopted in the Hyde Amendment.

strued governing federal Medicaid coverage provisions, ignored the interpretation of these provisions advanced by the federal agency which administers the Medicaid program as well as the teachings of this Court in *Maher* v. *Roe, supra,* and *Quern* v. *Mandley,* 436 U.S. 725 (1978) which mandate federal courts to construe Congressional grants of discretionary authority to the states in a generous and not restrictive fashion. By so reading Title XIX, these courts have utterly usurped the prerogative of states to fashion medical assistance programs, as a whole and not only with regard to abortion services, in accordance with reasonably perceived needs of the Medicaid population. More appropriately, the State of New Jersey submits, this statute must be construed as affording states broad latitude in limiting coverage based upon legitimate and reasonable fiscal, medical, moral or State policy bases.

In choosing to afford to certain groups of its needy citizens the benefits provided under the federally-assisted and state administered medical assistance program, a participating state must agree to reimburse providers of inpatient hospital services for the "*payment of part* or all of the costs" of these services, 42 U.S.C. §1396d(a) (emphasis added). See also 42 U.S.C. §1396a(a)(1), 42 U.S.C. §1396a(a)(13)(B). As is evident from the limiting language of 42 U.S.C. §1396d(a) and the reference in 42 U.S.C. §1396 to the state's provision of "medical assistance" "*as far as practicable under the conditions in such state*" (emphasis added), Congress clearly was not mandating comprehensive coverage of any category of care. See also *Beal* v. *Doe, supra* at 441. Again the statement in 42 U.S.C. §1396a(a)(13)(D) referring to "inpatient hospital services provided under the [State] plan" emphasizes the Congressional intent to afford participating states broad discretion in fashioning the parameters of its mandatory services coverage.

The limited federal objectives are further apparent from the legislative history of the program. As originally enacted Title XIX would have required participating states to move toward, and eventually to furnish, "comprehensive care and services to substantially all individuals who [met] the plan's eligibility standard with respect to income and resources" by July 1, 1975. 42 U.S.C. §1396b(e), as enacted by Social Security Amendments of 1965, Title XIX, §1903(e), Pub. L. 89-97, 79 Stat. 286, 350. Recognizing the significant and increasing burden of Medicaid costs upon State finances, Congress in 1972 enacted a number of amendments to Title XIX for the express purpose of affording states fiscal relief and additional administrative latitude. Included in these amendments was a provision which repealed section 1903(e). Social Security Amendments of 1972, Pub. L. 92-603, Title II §230, 86 Stat. 1329 (1972). For similar reasons, Congress repealed section 1902 (1) which barred state reduction of approved expenditures from one year to the next. By enacting and then repealing these sections, Congress thus made clear that Title XIX in its current form does not require comprehensive coverage even of mandatory services.

The correctness of the First and Seventh Circuits' interpretation of 42 U.S.C. §1396, as allowing state discretion in determining coverage of medical services falling within mandated categories of care, is further substantiated by the Court's ruling in *Quern* v. *Mandley, supra.* Therein the Court considered whether the definition of "emergency aid to needy families with children" es forth in 42 U.S.C. §606(e) imposed mandatory conditions of eligibility for every state Emergency Assistance program. Concluding to the contrary, this Court noted that a literal implementation of public welfare programs as broadly defined in the general purposes clauses of the

various Social Security Act chapters "would create . . . entirely open-ended program[s], not susceptible of meaningful fiscal or programmatic control by the states." *Id.* at 746. A more reasonable Congressional objective, this Court opined, was the establishment through these provisions of permissible limits of federal spending, rather than the definition of mandatory coverage areas for participating states. *Id.* at 745. Consistent with these principles of construction this Court interpreted the language of 42 U.S.C.§ 1397, the appropriations section for Title XX Social Services programs, whose declared purpose was to "encourage[ ] each state, *as far as practicable under the conditions in that State* to furnish services directed at the goal of . . . achieving or maintaining economic self-support to prevent, reduce or eliminate dependency" (emphasis supplied), as an expression of Congressional intent to delegate to the state ultimate decision-making authority in establishing priorities within the constraints of federal funding limitations." *Id.* at 745.

Similarly, the lone appearance of the term "necessary medical services" in the almost identically worded appropriation section for the federal Medicaid statute (42 U.S.C. §1396) cannot be viewed as imposing a substantive coverage requirement. As with the appropriation sections of Title XX and the Emergency Assistance definition, the use of the term "necessary medical services" simply specifies the type of services for which federal matching funds will be available. It does not establish the minimum limits of a participating state's mandatory service coverage.

The failure of the Title XIX legislature to prescribe minimum levels of coverage and its use of such broad phrases as "reasonable" and "consistent with the objectives of the Act" certainly belies any intent on the part

of Congress to limit in any significant manner exercise of state discretion in determining an appropriate level of coverage. As the Court noted in *N. Y. State Dept. of Social Services* v. *Dublino,* 413 U.S. 405 (1973), where there exists no "direct and unambiguous language . . . either in the federal statute or in the Committee reports . . ." evidencing such a limitation, a Congressional intent to preempt State discretion should not be presumed *Id.* at 414. Similarly, had Congress intended to preempt the exercise of state discretion as to coverage of abortion services, it would have clearly stated its objectives by succinctly defining both federal standards as well as the permissive areas of discretion reserved to the states. Like the Work Incentive Program reviewed in *Dublino,* "no such expression exists" in Title XIX. *Id.* at 417.

In view of the above lack of Congressional definition of the required amount of care and services or any specific direction to the Secretary of HEW to prescribe such definitions, the Secretary has largely left to state discretion the formulation of state plans for coverage. See *Virginia Hospital Association* v. *Kenley, supra.* A state plan thus must

> "Specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the categorically needy and to the medically needy, if the plan includes this latter group. *Such items must be sufficient in amount, duration, and scope to reasonably achieve their purpose.* With respect to [these] required services . . . the State may not arbitrarily deny or reduce the amount, duration or scope of such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition. *Appropriate limits may be placed on services based on such*

criteria as medical necessity or those contained in utilization or medical review procedures." 42 C.F.R. § 449.10(a)(5)(i). (Emphasis supplied.)

It is apparent from the above regulation and the arguments it has presented in *Virginia Hospital Association* v. *Kenley, supra* and *Rush* v. *Parham, supra* that HEW does not view medical necessity as the sole basis upon which coverage of mandatory services may be limited. Indeed the State is free to place other "appropriate" limits upon mandatory service coverage.* Thus, contrary to the theory set forth in the opinion below, *Rush* v. *Parham, supra,* and *Doe* v. *Busbee, supra,* where a state can reasonably justify upon an appropriate policy basis a limitation upon coverage as permitted by the last paragraph of §449.10 (a)(5)(i), it is evident that the reduction of the affected services does not arise "solely because of the diagnosis or type of condition" and does not constitute an arbitrary denial or reduction in the "amount, duration or scope of such services."

Therefore the sole basis upon which a state limitation of coverage can be overturned is if it fails to advance a significant and rational State policy. In the area of abortion coverage it is evident that states have significant concerns regarding the use of state monies to fund abortions. Indeed, as this Court has previously recognized, there is nothing "in either the language or legislative history of Title XIX . . . [which] suggests that it is unreasonable for a participating state to further [the] unquestionably strong and legitimate interest in encouraging normal childbirth." *Beal* v. *Doe, supra* at 446. In view of the above

* Of course the interpretation of the federal statute by HEW should be accorded great deference by the Court. See *N.L.R.B.* v. *Bell Aerospace Co.,* 416 U.S. 267 (1974).

and the arguments presented in Point I *supra, amicus* submits that a state's denial of Medicaid funds for abortions for non-life-threatening health conditions is clearly justified as against any claim of arbitrariness. Accordingly, this Court must conclude that the denial of Medicaid funds for medically necessary abortions other than those required by health conditions threatening the life of the mother is both a reasonable and appropriate exercise of state discretionary power vested by the Social Security Act.*

CONCLUSION

The Seventh Circuit Court of Appeals improperly construed Title XIX of the Social Security Act and the Hyde Amendment as barring participating Medicaid states the discretion to limit coverage of abortions to those necessary to preserve life of the mother. Furthermore, the District Court's conclusion that the denial of Medicaid cover-

* It is amicus' position that the history of the Hyde Amendment merely confirms the fact that Congress never intended to mandate comprehensive coverage of "medically necessary" abortions. See e. g. 123 Cong. Rec. H. 12653 (Daily Ed. December 6, 1977) (Rep. Michel: ". . . I well know that in Cook County . . . they are taking care of situations that we are prohibiting here, but they feel a need locally to do it and if there are no federal funds, I have no voice in it. . . ."); 123 Cong. Rec. H 10835 (Daily Ed. October 12, 1977) (Rep. Early: ". . . I believe that it is not the Federal Government's place to provide funds for abortions. Should the majority of the residents of individual states choose to spend their State tax dollars to fund abortions, that is their right.")

Were this Court however to determine *contra, amicus* submits that the ruling below as well as the *Preterm* opinion are persuasive that the Hyde Amendment does constitute a substantive amendment of this requirement.

age for all abortions deemed medically necessary by a physician violates the equal protection clause of the Fourteenth Amendment failed to give proper consideration to the court's ruling in *Maher* v. *Roe,* 432 U.S. 464 (1977), *Gedulig* v. *Aiello,* 417 U.S. 484 (1974), *Jefferson* v. *Hackney,* 406 U.S. 535 (1972), and *Dandridge* v. *Williams,* 397 U.S. 471 (1970). It is respectfully submitted that the application of the principles enunciated in these cases clearly demonstrates that the decision below is erroneous and should be reversed.

Respectfully submitted,

JOHN J. DEGNAN,
Attorney General of New Jersey,
Attorney for the State of New Jersey.

ERMINIE L. CONLEY,
Assistant Attorney General,
Of Counsel.

ANDREA M. SILKOWITZ,
Deputy Attorney General,
On the Brief.

see

7 9

4

4 9 1

1 2 6 8